

**HDHP Task Force
December 4, 2019
11:00 AM – 1:00 PM
Legislative Office Building, Room 2D**

Members Present: Sean King (Designee), Dr. Daniel Freess, Susan Halpin, Atty. Robert Krzys, Joseph McDonagh, Cassandra Murphy, Janice Perkins, Seth Powers, Dr. Gregory Shangold and Dr. Andy Wormser;

Not in attendance: Ted Doolittle, Dr. Andrew Lim, Patrick McCabe

OHA Staff Present: Adam Prizio and Sherri Koss

Welcome

- Sean opens meeting at 11:00 AM and reviews the safety rules (exits) and introduces OHA Staff

Roll Call

- Dr. Andrew Wormser
- Cassandra Murphy
- Dr. Daniel Freess
- Dr. Gregory Shangold
- Robert Krzys
- Seth Powers
- Susan Halpin
- Janice Perkins
- Joseph McDonagh

Appointment of Temporary Chair

- Sean states he is willing to be appointed as temporary chair and asks for a motion; Susan Halpin motioned to approve and Dr. Daniel Frees seconded; no nays, no abstentions, no discussion, motion carries unanimously

Approval of Agenda

- Sean asks for motion to approve agenda, Dr. Andrew Wormser motioned to approve and Joseph McDonagh seconded; no nays; no abstentions, no discussion, motion carries unanimously

Approval of 11/20/19 Minutes

- Sean asks for motion to discuss or approve minutes, Janice Perkins motioned to approve and Cassandra Murphy seconded; no nays, no abstentions, no discussion, motion carries unanimously

Public Comment

- Jill Zorn – Universal Health Care Foundation of Connecticut
 - Jill states that HDHP's are not working for the people of CT and that the consumers of Connecticut are relying on us to have a constructive conversation and keep their needs in mind

Presentation by Dr. A. Mark Fendrick, MD-University of Michigan, Center for VBID

- Adam introduces Dr. A. Mark Fendrick
 - He is the Director at the Center for VBID.
 - Professor of internal medicine at the School of Medicine as well as the Professor of Health Management and Policy at the School of Public Health at the University of Michigan
 - He conceptualized and coined the term VBID
 - The VBID Center is a leading advocate for development implementation and evaluation of innovative health plans and has many other accolades
- Dr. Fendrick thanks Gov. Malloy who was the first to bring VBID to the state of Connecticut, along with Governor Lamont
- Look at the role of VBID principles in HDHP space specifically in the area of HSA qualified HDHPs
- Connecticut remains at the tip of the spear in implementing and evaluation of VBID.
- If we are going to continue support innovation and support the known services that improve individuals and population and health the likelihood of total spending going down is extraordinarily low likelihood
- Dr. Fendrick spends time identifying, measure and reduce low value care to create headroom so folks can receive services covered more generously
- Almost all discussions around healthcare in the United States on the state level and individual employer level is about spending money as opposed to the health of individuals and populations. We significantly underutilize services deemed high quality which are cost effective but not cost saving
- Dr. Fendrick feels that there is plenty of money in the US health care system but we are spending it in the wrong ways. He feels that the supply side has moved slowly, but in the right direction.
- Now trying to understand consumer facing levers, primarily the lever used on the demand side across the board in this country is consumer cost-sharing; in other words making our population pay more for all care
- Americans do not care about healthcare costs, they care what it costs' them
- What concerns Dr. Fendrick is the growth of deductibles and that insurance doesn't kick in until the deductible is met
 - For single people with employer insurance it is an average of \$1,000
 - For family the average is over \$2,500
 - The Federal Reserve posted last year that 40% of Americans don't have \$400 in the bank
 - Deductibles restart come January 2020 or at the start of a given plan year
 - Dr. Fendrick pushes against the concept of skin in the game but is not against deductibles or having his patients pay. He is against his patients having to have a bake sale in order to get access to insulin or cancer therapies.
 - Rising co-payments worsen disparities and adversely affect health. Out of pocket costs impact negatively for people who have multiple chronic issues and those socioeconomically challenged
- With bi-partisan support VBID was introduced into the Medicare program called CMMI Medicare Advantage VBID model test
- It was the first ever to waive the uniformity rule which said every Medicare beneficiary has to have the exact same coverage. The same for Tri-care (military plans)
- You can screen for HIV, breast cancer, hypertension, etc. with no cost to the patient, however the same legislation that created the safe harbor, had a line in the regulation that did not allow for any pre-deductible coverage of any service that covers an existing illness, injury or condition. The problem with this is that consumers don't have the money to follow-up with what is found in pre-deductible screening because of the amount of dollars needed to follow up

- For the past 14 years he has been working to advocate for a change for more generous pre-deductible coverage not only for primary preventive services mandated by ACA Sec. 2713, but those very highly valued secondary preventative services that are, in his opinion, as or more important to his patients' health
- In July 2019, the Trump administration signed IRS Notice 2019-45 which allowed HSA qualified HDHPs to cover services for individuals with chronic conditions
- This list is much smaller than clinicians want
- In speaking with Secretary Azar, about no American, come January 2020, should have to pay full price for services such as insulin, again
- The Chronic Disease Management Act of 2019 is a bipartisan, bicameral legislation which will markedly expand the IRS list
 - Third time being introduced to Congress
 - This will not mandate pre-deductible coverage but allow high deductible health plans to provide chronic disease prevention services to enrollees
- Pleased to see the success with Connecticut's HEP plan
- There are two traditional ways to pay for higher access and affordability for the services Dr. Fendrick begs his patients to do:
 - Raise premiums for all – this is an equitable approach if you follow the textbook of insurance
 - Problem is over 50% of Americans don't use their health plans at all which makes raising premiums a bad idea
 - Shift increasing cost of care to people who use their care by increasing deductibles, co-payments and co-insurance
 - Dr. Fendrick calls this a tax on the sick; over two-thirds of the plans have not taxed the sick and healthy together, instead they decided to tax the sick
- We have, in Dr. Fendrick's opinion, pushed deductibles to such an extent that they mostly impact the sickest and the poorest people
- We are now finding deductibles in the negative clinical effects extending in significant proportions of people who see these plans
- Dr. Fendrick would strongly argue we don't want to raise deductibles any further
- Substantial amount of money spent is on services that don't make Americans any healthier
- Reduce spending on low-value care
- Five commonly overused services
 - Diagnostic testing and imaging prior to low risk surgery
 - Vitamin D screening
 - PSA Screening
 - Imaging in first six weeks of acute low back pain
 - Branded drugs when identical generics are available
- Dr. Fendrick has a study that shows if you take 60 of the most commonly used drug classes and move them from requiring deductible to exempt, you would only need to change the actuarial value or reduce about one percent of your spending on low value services
- What Dr. Fendrick hopes will come out of these discussions are plans called VBIDX
 - which will lower cost-sharing
 - meet with actuary and find out how much they cost
 - look at low-value care

- Raise cost-sharing on those things
 - Pay dollar for dollar to create VBID type plan without having to raise premiums or deductibles
- Blunt deductibles that are applying same deductible requirement on services deemed as high-quality as those deemed low value care
- Wants more nuance on deductibles
- Wants more high-value services on pre-deductible basis
- Find out cost to a public and private payor, if you need to be cost neutral, to expand this coverage to high value services
- Critical aspect to this is that you must be much more aggressive in identifying and measuring low value care, keep deductibles on these high
- New benefit design that builds, on the State of CT HEP plan, that pays for the increase spend on high value care with increasing cost sharing or other levers to get rid of waste in the healthcare system

Questions:

- **Seth Powers** has two questions:
 - Refers to Dr. Fendrick's example of when Pitney Bowes instituted VBID in the late 90's or early 2000's is my understanding correct? Dr. Fendrick responds, yes, correct.
 - With that, have there been longitude health outcome data set that have come out that demonstrate the effectiveness of health outcomes, not cost, from the implementation of the plan. Dr. Fendrick responds we have decades of data that if patients take their Statin that fewer heart attacks will occur
 - Small studies, one done by Aetna called MI Freee, gave patients, who have known coronary disease, their drugs at no cost compared to the standard Aetna plan.
 - There have been specific studies in specific conditions to show improved health outcomes especially for those socioeconomically challenged. In terms of studies spanning decades there are none that he knows of.
 - Seth asks for VBID implementation have you seen variations with their HDHP with or without HSA options available? Dr. Fendrick can't speak of any VBID implementation on an HSA qualified plan. Dr. Fendrick further shares that non-HSA plans can do a VBID but there is very little literature on impact of VBID in high deductible plans. For services on pre-deductible bases there is a fairly large amount of literature.
- **Dr. Shangold** ask with MIPS, MACRA and Choosing Wisely there is a large push to high value services. They were trying to limit head CT's and non-traumatic headaches and ultimately bad diagnosis' were missed. Is there any information about providers being indemnified by following Choosing Wisely or certain guidelines? Dr. Fendrick responds that VBID is so granular in the fact that the issue on whether clinicians would be indemnified for doing right or wrong is above his pay grade but states this is not the intention of Choosing Wisely. It's about conversation. No service is a high or low value, just underused. He thinks the efforts are trying to identify services underused such as colonoscopy and overused like CT scanning.
- The patient responsibility portion of this which, if provider recommended getting a colonoscopy at 50 and don't go, people complain. There is this whole service element within the system where complaints, when you follow these guidelines, are to be attributed to. Dr. Fendrick feels that he used the wrong example. Just because a patient wants something doesn't mean a provider should give it. VBID program in the State of Connecticut HEP plan was the first of its kind to have a participation requirement. Dr. Fendrick strongly support initiatives that enhance the need for patient accountability, but feels his patients shouldn't have to foreclose on their house to get cancer therapy, particular in January because their plans have such a high deductible they can't meet.

- **Janice Perkins** shares that ConnectiCare has worked hard and is proud of what they have accomplished and feels this works very well for the large group market? There have been many attempts in Connecticut to do something with the small group market. How would individual and small groups that are on the exchange benefit from your work and VBID? Dr. Fendrick states that the VBID X project is perfect for the exchange market because had to keep the AV the same, but don't need to use verbatim. Can't raise premiums or deductibles in a metallic tier because the actuarial value needs to be the same. Janice thanks Dr. Fendrick and states she looks forward to him sending the report and looks forward of any comments regarding its applicability in Connecticut

Report to the Legislature

- Sean speaks on the report, the look and content
 - Draft has already been started
 - The report will begin with a summary of presentations and information gathered
 - The components will be that which represents the charge of the legislature to the task force
 - Timing – start discussions today on what some of that content will be
 - Time will also be carved out at the next meeting for further discussion and analysis of the recommendations
 - Our guest speaker will help with the analysis of those recommendations by the task force
 - Hope to be able to fashion a draft report from the committee discussion after the next meeting

Discussion of Proposed Findings & Recommendations of the Task Force

- This list was put together from the presenters and comments from the committee members
- This list is in no way an endorsement of any of the items by OHA, though OHA may support one or more after enough adequate discussion of the committee
- Susan requests reading off the charge for the task force so we are all reminded. Sean reads Public Act 19-117
- Comments/discussions:
 - Focus on the charge and some of the ideas don't apply to HDHP or the charge
 - There is agreement with this comment, no silver bullet to address all these issues and need to define what we want to focus our attention and efforts
 - Non HSA's can cover more than HSA plans and they have a place in the market
 - Components need to go along with any recommendations needed
 - This committee is missing constituencies around the table, needs representative from AHCT, this is an important piece missing here
 - Possibly have the Exchange explore some of these things; what can and cannot be done within the metal tiers;
 - Concerns over the exchange, metal tiers; a couple of points feels there may be a silver bullet within the silver plans with VBID X; recommend to the exchange explore alternative plans
 - Consider financial impact on peoples' lives on HDHP
 - Exchange is starting the work at this time, looking at plan design; they can help committee look at product design
 - Can we agree on some guiding principles, review based on scope; urging the legislature not to run afoul on the federal HSA rules, not mandating a benefit where there is an HSA that would run afoul of the HSA rules
 - Member engagement critically important
 - Some education on how to pick the right plan, is there support for enrollees who only have 30 minutes to enroll, navigators, who pays?
 - Hopes the committee can start to shrink the scope of HDHPs

- Should we explore which of these do go towards the charge, some we won't be able to work on within the scope of this committee, 35% of the market is a good start
- The impact could benefit from further study and analysis; very much connected to a socioeconomic status compared to across the board, education component
- Look at the elements of bad debt and judiciary process, surprise billing, financial incentives
- Carriers being responsible for the deductible; doing so would impact the ability to utilize HSA's in this state
- Banter back and forth on this point, 502 IRS publication HSA's can be used to pay healthcare premiums; some members want to analogize this to paying carrier for deductible advance; some members dispute this analysis
- Literacy component could be a start
- Putting the list in a more organized order, group alike items by category
- Can we agree that the bipartisan legislation before Congress is something we would endorse as it deals with HDHP; not much control of HSA compatible plans
- Have to be careful of doing things that so raise the premiums that people will abandon the marketplace
- One by one review of list
- Some of the language in the suggested findings could be softened and made more positive than negative
- Support for inclusion of literacy in the report

Discussion and Possible Vote on Proposed Resolution

- Dr. Shangold motions to accept the proposed resolution, no seconded; motion does not carry

Sean asks for motion to adjourn the meeting. Joseph McDonagh motioned to adjourn and Susan Halpin seconded. Meeting adjourned by unanimous vote at 12:50 PM

Next meeting will be held on
December 18, 2019
11:00 AM – 1:00 PM
(LOB) Room 2D