**HDHP Task Force**
**December 18, 2019**
**11:00 AM – 1:00 PM**
**Legislative Office Building, Room 2D**

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**Members Present:** Ted Doolittle, Dr. Daniel Freess, Susan Halpin, Atty. Robert Krzys, Joseph McDonagh, Janice Perkins, Seth Powers, Dr. Gregory Shangold, Dr. Andy Wormser, Dr. Andrew Lim, Patrick McCabe and Cassandra Murphy (via phone)

**OHA Staff Present**: Adam Prizio, Sean King, Valerie Wyzykowski and Sherri Koss

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## Welcome

- Ted opens meeting at 11:03 AM

## Roll Call

- Dr. Andrew Wormser
- Cassandra Murphy (via phone)
- Dr. Daniel Freess
- Dr. Gregory Shangold
- Robert Krzys
- Seth Powers
- Ted Doolittle
- Dr. Andrew Lim
- Susan Halpin
- Janice Perkins
- Joseph McDonagh
- Pat McCabe

## Approval of Agenda

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

## Approval of 12/4/19 Minutes

- Ted asks for motion to discuss or approve minutes, Janice Perkins motioned to approve and Dr. Wormser seconded; no nays, no abstentions, motion carries unanimously to approve as amended
  Some discussion small changes to be made to minutes

## Discussion to schedule January Meetings

- Tabled until the end of this meeting
- Ted reminds all that public comments of any length should be submitted to Sherri Koss at Sherri.koss@ct.gov for distribution to the committee and for posting

## Public Comment

- Paula Haney – Physical Therapist
    - Volunteer and works with the Arthritis foundation for over 40 years
    - Many HDHP are attractive because of lower premiums
    - Those with chronic illness eat up their deductibles early
    - Son is on Humera which costs $6,000 per month without insurance; with a HDHP that deductible is eaten up in that first month
    - Most people don't have $6,000 saved up
    - In CT nearly 44% of residents have $1,000 or less in their savings account
    - Hopes that looking at these numbers and people with chronic care perhaps there are options; that certain services are deductible, for example preventative services and illness maintenance
    - Biologics are life changing and without these many people would be on disability
- Written testimonies submitted by and distributed to committee members:
    - Kristen Whitney Daniels – Connecticut #insulin4all
    - Joshua Levin – Senior at Central CT State University
    - Dr. Michael Aronow - Connecticut Orthopaedic Society

## Presentation by Ann Lopes – Access Health

- Access Health Connecticut created as a result of the Affordable Care Act and is the only place to qualify for financial help to lower consumer costs through premium subsidies or cost-sharing reductions or both
- Standard Plans are those where AHCT prescribes cost sharing, lower deductibles, co-pays for a subset of covered services. Insurers who wish to sell on the Exchange must maintain certification from AHCT
- These plans are reviewed each year and approved by the Board of Directors
- Approximately 3.3 million people Insured in CT with about 111,000 in the individual market and approximately 120,000 in the Small Group Market. This is the population subject to fully insured plans that are ACA compliant, leaving about 1.7 million people in the large group, probably self-insured plans
- In 2020 there are approximately 6 plans that filed with the Insurance Department that are listed as HSA compatible health plans, with a projected enrollment of about 22,600 or about 15%-20% of the population participating in the individual market for 2020.
- Not on the slide, but in the small group market about 57 of the 164 plans submitted to the insurance department were listed as being HSA compatible plans, according to Ann's survey of plan names and other information found in CID filings. Of those approximately 50,600, which is the total small group market that was submitted to CID. By implication it includes off-exchange especially since Ann says that she took this number from looking at the plan names and some other data, which is different to her analysis of the on-exchange plans.
- Slide 7 shows the feature of the plan, the value of that feature and then the explanation on whether the cost sharing for that feature would meet IRS compliance in order for plan to qualify as a HDHP – Standard Gold Plan example shown. The red arrows indicate non-compliance with IRS guidance on HDHP that would qualify to have an HSA paired with them, whereas the green arrows could be compliant with that element. A mix of would indicate the plan would not be compliant as a HDHP in terms of the IRS guidance
- All ACA plans through AHCT do have to meet actuarial value requirements as it is a federal regulation
- Insurance department reviews each year as part of their filings

- The Gold Plan actuarial value range permissible for a plan to be compliant with Health and Human Services guidelines to 76% – 82%, which means that the insurance company sponsoring that plan would pay on average 76%-82% of claims that come in for the entire insured population.
- Gold plan not qualified as HDHP per IRS guidance. It has a deductible that is split between medical and prescription and is less than the minimum $1,400 deductible required as a single enrollee plan for 2020
- ACA compliant plans can go up to an $8,100 out of pocket expense
- Silver plans have between 66%-72% actuarial value
- AHCT Standard Bronze HSA does qualify as an HDHP, there have been no changes in the benefit design for a while now and AHCT is waiting for the actuarial value calculator tool to be released for 2021
- AHCT has an education campaign called "Choose, Use, Be Well", launched this past year which encouraged enrollees to use their health insurance
- Many initiatives such as in-home chats, canvases of cities and small businesses
- Ann did review some of the consumer portal screens
- Annual Premium and Maximum Out of Pocket Estimates (Fairfield County). This slide are people who are not subsidy eligible
- The HSA HDHP compatible health plan (the Bronze plan) is the best option for someone expecting a 3-day hospital stay
- In some situations the overall value of a plan, even though it has a high deductible and challenges with regard to the financial outlay potentially coming at one point in time or in a short period of time, it does end up being overall low cost option
- Medical Loss Ratio (MLR)
    - The Affordable Care Act (ACA) requires health insurance issuers to:
        - Submit data on the portion of premium used to pay for covered services & quality improvement
        - Spend at least 80% (Individual & Small Group) or 85% (Large Group) of premium dollars on medical care/quality improvement, unless alternate standard has been approved in the state
        - Provide a rebate to consumer when the MLR standard is not met
- Access Health Connecticut (AHCT) input for Task Force
    - Numerous health literacy initiatives
    - Navigators are trained and able to assist consumers with health coverage
    - Federal regulations requiring pricing information be publicly available
    - AHCT standardized plans for the individual market
    - Cost sharing reduction (CSR) plans in the individual market through AHCT lower the amount a lower income consumer pays for deductibles, copayments and coinsurance
    - ACA requires preventive care not be subject to plan cost-sharing, including for HDHP's
    - Offering only HSA-compatible HDHP's through the exchange is contrary to AHCT mission
    - AHCT plans eligible for cost sharing reductions would not qualify as HSA-compatible HDHP's
    - ACA regulations have addressed issues pertaining to value of prescription drug manufacturer coupons counting towards plan-out-of-pocket maximum

Questions:

- **Ted** asks do we have a breakdown of the 20,600 enrollees (in HSA-eligible plans on and off the exchange in the individual market) who were subsidized vs. non-subsidized. Ann respond the 20,600 enrollees includes about 15,000-16,000 on the exchange and there is no information at this time. Typically in January or February a full blown report of enrollment comes out, but due to the extension of open enrollment we do not have that information at this time. Ted asks of the people who buy the HSA eligible ones, do you think the breakdown is similar to other non-HSA compatible population (about 70%) usually subsidy eligible? Ann responds there is a proportion of enrollees who take HSA compatible plans even when they are subsidy eligible. Could be because of the plan design. The subsidy in 2020 is going to be sizeable. This would give someone a very low deductible and if the person is healthy they would take the plan, even though this could be a risk because if someone is between 130% and 158% of the FPL (federal poverty level), they may not have enough money on hand to pay the deductible, if they get sick. Ted questions of the people who buy an HSA eligible plan, is there any information to know how many of them have, or opened, an HSA account. Ann responds that they do not capture that information. Has there ever been any thought from AHCT to providing people who just selected an HSA plan providing links or other support on where they can refer people to open an HSA? Ann likes that as a take-away.
  **Dr. Wormser** questions the Medical Loss Ratio (MLR) is this calculated after the deductible, do I understand correctly? Ann responds what she believes happens is that it is done at the carrier level. Thus, the carriers should be taking into account the total amount of patient contributions across their insured population to come up with the MLR. Carriers are allowed to exclude things such as taxes from the calculation and are allowed to include their costs for quality improvement programs, in addition to the actual claims dollars. Much information on the CMS website. Is 70% of the people on AHCT plans, not Medicaid, receiving federal subsidy? Ann says that's about right. Dr. Wormser feels the figure on the Connecticut population chart is off. Ann clarifies and reviews the numbers again.
  **Janice Perkins** provides perspective on numbers. ConnectiCare has about 76,000 members on the exchange and about 11,000 on HSA compatible plans (ConnectiCare only). The most popular for their members is the Bronze standard plan. Has about 25,000 members in a cost sharing reduction option. Feels it is important to know that there are two types of subsidies, one being the advanced premium tax credit (APTC) which reduces the premium for folks under the 400% FPL and that can be coupled with a cost-sharing reduction plan. Would you agree that I stated this correctly? Ann states yes. Has your committee looked at offering VBIDs? Ann responds yes and feels it this discussion will come up in the 2021 plan year. One of the challenges they find looking at VBID's is that they only have two carriers on the exchange at this time and the carriers have to evaluate whatever is being considered by the committee to determine if, based on their own data, the actuarial value for that plan would be met with the parameters required by CMS as well as mental health parity.
  **Sue Halpin** feels that a large majority of this population is subsidized so they are not paying the copayments. Feels we need to zero in on the population we're looking to address and again states looking out for unintended consequences. Is it a fair statement that negating the ability to offer high deductible plans that don't meet HSA standards could have significant unintended consequences? Ann responds yes and that the key is HDHPs have specific requirements per IRS guidance. Based upon your comments about not tracking those that have an HSA account, your figures included in presentation in terms of cost savings don't include any tax benefit, that may come for an HSA account too, correct? So there could be an added advantage to a

consumer to have an HSA plan? Ann responds yes. Sue further asks is there currently an offering on the exchange that has no deductible. Ann responds the only person qualified for a plan with no deductible would be someone who is between 138% and 150% of FPL who chose to enroll in the Silver plan where that plan has a $0 deductible and a $900 out of pocket (OOP) maximum. Sue comments on the mission statement of AHCT and feels that the board keeps in mind the mission when designing standardized plans. Ann confirms. Sue states that the Federal Rules around AHCT policy and procedure are constantly changing so whether CMS issues a new guideline or the latest on health reimbursement accounts and tax advantages associated with these are changing, I would imagine we would need to rely on AHCT expertise on the impact of those changes on the population you serve. So if the legislature chooses to act on some of the things discussed at this table, could hamstring AHCT from doing certain things that they need to due to federal regulatory changes. Is this accurate? Ann responds our timing for making changes in standardized plans begins now and typically ends in April because we go to our board and look for approval on recommendations of the committee and the carriers need to file plans with CID in July. So final decisions need to be done to the carriers can take all that information, both state and federal legislation items and incorporate that into their pricing and plan designs.

**Joseph McDonagh** feels this past year has been very difficult for his clients. The advanced premium tax credit is based on the second least expensive Silver plan. Is this why there is no HSA silver plan on the exchange? Ann responds yes, they decided not to permit an HSA compatible HDHP. It's more along the lines that anything available in the individual exchange in the Silver metal level will have cost-sharing reduction subsidies. So for a cost-sharing reduction plan at the 80% – 94% actuarial value level it would be virtually impossible to still meet the requirements of IRS guidance with regards to the plan qualifying as a HDHP, so it doesn't make sense from AHCT point of view.

## Presentation by Profession Sabrina Corlette – Georgetown Law Center for Health Insurance Reform

- Sabrina states that the way to fix this is to look at prices (prescription and provider prices)
- She studies health insurance across all 50 states all day every day
- 33 States rely on the Federal Government to run the exchange while Connecticut runs it itself (AHCT), Access Health Connecticut. This is good because we are able to do some consumer oriented things that the Federal Government run programs can't. Those plans don't have access to the data that was presented today by AHCT.
- 3 State Activities to address high cost-sharing:
    - **Benefit design**
        - Not aware of any state extending standardized benefit design to the group market
        - When thinking about the silver level tier, there's a range of actuarial value that you can try to get to. The higher you are, closer to the 72%, that increases your premium cost. This can be good for the subsidized folks, because their premium tax credits pegged that premium, but it increase the premiums for the unsubsidized folks. This is a balancing act that some states have struggled with in respect to standardized benefit designs
        - Some states have used the existence of pre-deductible coverage as a marketing tool. DC feels they can get more people covered if people know they can get high value services covered pre-deductible. California says that not only does it help get people covered but it helps keep them covered
        - Health plans have been trying to deal with the rising cost of prescriptions by changing the formulary design and increasing enrollee cost sharing for the more expensive drugs. Some states have placed limits on formulary designs
        - The states that cap cost-sharing do it in different ways

- Questions
  - **Dr. Wormser** asks for the states that have encouraged pre-deductible coverage, is there any data on how the people have done from the health outcomes view? Sabrina responds that she wishes there was and feels this is important information to capture.
  - **Seth** asks do the pre-deductible elements vary from state to state and is there cost effective analysis that goes into it? What is the science behind the decisions? Sabrina says she has asked states about the clinical science that goes into the decisions and feels that there is not much. There is a committee (multi stakeholders) responsible and they get a few plan designs that meet the actuarial value and state and federal levels and just choose. Not a lot of clinical input on this
- **State Activity on Hospitals' Community Benefit**
  - Sabrina states that they are already seeing an uptick of attention by policy makers regarding hospital debt collection. This is not only from uninsured but also from insured, even though they have good employer insurance, due to the high deductibles
  - Reports done on debt collection
  - Under Federal law in order for a hospital to maintain non-profit status they have to conduct community needs assessments and develop plans to meet those needs
  - Several states have taken steps such as:
    - Oregon has most comprehensive laws in this area. They assign each hospital a community benefits spending floor. It also extends the requirement for hospital financial assistance programs to all clinics and outpatients facilities they own.
    - Illinois sets a floor community benefits amount to spend equal to what they pay in property taxes.
    - In Minnesota, all hospitals have an agreement with the Attorney General's office that they have to take into consideration the patient's ability to pay in their charity care policy
    - Massachusetts laid out billing guidelines, and collection attempts can't begin until the hospital has determined if a patient is eligible for financial assistance
    - States have implemented more reporting and transparency requirements so a number of states have reporting requirements that are above federal requirements
    - Georgia requires hospitals to post commonly on their website community benefit spending reports as well as salary information for their top 10 highest paid employees
    - California and Rhode Island focus on vulnerable populations
    - Regular evaluations of what hospitals are doing in this area is a focus for California, Massachusetts and Rhode Island
    - New York made reporting an assessment of what hospitals are doing in this area a condition of approving mergers and/or receiving a certificate of need
- Question(s):
  - **Dr. Shangold** asks if these rules apply to physicians. Sabrina responds that they only apply to non-profit hospitals. Dr. Shangold asks is there are any details about patients who have these financial burdens being sued by the people who provide their care, and how this may interfere with them seeking further care that they may need. Sabrina responds there is strong evidences that high deductibles cause patients to forego care but hasn't seen such data as to consumers who are being sued and whether or not that affects how and whether patients seek further care. An educated guess would suggest it does.

- **Consumer Education/Assistance**
  - The Robert Wood Johnson Foundation did a comparison on Decision Support Tools. It shows different states and how they vary. Most state based exchanges have out of pocket cost calculators. These calculators will point the consumers to plans that will help on the cost-sharing as well as out of pocket costs. Sabrina showed some slides from states that she felt the visuals were good in order to help consumers.
  - Navigator and broker assistance increases successful enrollment
  - Connecticut did not respond to their survey so does not have Connecticut data to share
  - Relative to the federal market place, the state market places are outspending quite dramatically with respect to navigator funding and advertising.
- Questions:
  - **Seth** asks if Sabrina is aware of any surveys, customer satisfaction or consumer literacy surveys that have been a result of some of these efforts to understand what the effectiveness is and where the investment belongs? Sabrina responds that there is not great data, but there are reports that navigators and brokers really do drive enrollment up. Navigators can be helpful with lower income populations and reports show it really does help. As for decision support tools, she has not seen any great data but feels that it is important for consumers to receive the information at the point in time they are making their decision. Seth asked, for navigators used in supporting enrollment is there any quality check or audit for any of those plans selected based on the individual needs. You can have a centralized automated system at the point of sale where you can control guidance or a decentralized where you have less control over the guidance. Sabrina responds that navigators and brokers have to go through training through the exchanges. The federal government through healthcare.gov has a whole training curriculum that they have to go through and Sabrina assumes Connecticut does as well. With respect as to what happens after the fact, we do know that generally speaking consumer satisfaction with exchange products is pretty high, but most of us don't use our insurance all that often. If we receive 80% of consumers' satisfaction that are satisfied they are the percentage that really don't use the insurance. We really want to know the satisfaction of the 20% who have high usage of their insurance and then tie that back to the assistance they received.

## Other Business

- Discussion on scheduling meetings for January
  - Committee feels that we need at least two meetings and no more presentations
  - Dates recommended, doodle poll recommended
  - Sherri to send out doodle poll
  - Should members submit input on proposed findings to make the next meeting more effective
  - 2 point approach to the report (referring back to Bob Krzys' previous comments)
    - Recommend to the exchange that they look at HDHP's and how to build in VBID's with the understanding that they are trying to minimize the impact of HDHPs on consumers
    - Follow up and talk about some of the financial impacts and providers around the table have suggested that the carrier collect the deductibles and that could be something to forward to the exchange for exploration as well
  - If we took the groupings and distribute them to the members of the task force we should all respond to those specific groupings and rank their interest so when we meet again we will have an understanding of where we will start
  - Email will be sent out to the members with homework assignments

- Dr. Wormers shared a 2 page document with information on high value services by condition – distributed to committee members

Ted asks for motion to adjourn the meeting. Pat McCabe motioned to adjourn and Joseph McDonagh seconded. Meeting adjourned by unanimous vote at 1:00 PM

Next meeting will be held on
January 9, 2020
11:00 AM – 1:00 PM
Room LOB Room 2D