

**HDHP Task Force  
January 9, 2020  
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, Cassandra Murphy

**Members Absent:** Dr. Andy Wormser, Dr. Andrew Lim, Patrick McCabe and

**OHA Staff Present:** Adam Prizio and Sherri Koss

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**Welcome**

- Ted opens meeting at 11:01 AM

**Roll Call**

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

**Approval of Agenda**

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

**Approval of 12/18/19 Minutes**

- Ted asks for motion to discuss or approve minutes, Joseph McDonagh motioned to approve and Cassandra Murphy seconded;  
Discussion, Joseph McDonagh states that on page 3, third bullet point, ACA compliant plans can go up to \$8,150 out of pocket expense, not \$8,100 out of pocket expense; Susan Halpin motioned to postpone adoption of minutes until end of meeting in order to review minutes. Motion tabled to end of meeting;

**Public Comment**

Jessica Black – Consumer

- Shares her personal experience as individual with a HDHP. Milford native but getting BA at Central Mich. U. Had a car accident while living in Michigan which is a no-fault state (each person takes care of their own).
- Medical bills started rolling in and she has a \$6,000 deductible for in-network providers.

- Very few of her medical bills would be covered by health insurance because she was living in Michigan. Prior to moving there, she had asked about out of state coverage, was told no problem. After accident was told she should have purchased a higher premium plan in order to be covered. Had \$8,983 in medical bills to pay with a \$6,000 deductible out of her pocket before insurance would kick in.
- Her Father pays \$600/month for her coverage.
- Even with the best injury lawyers, she only received about \$3,000 in settlement against the other driver. This left her with a balance of \$5,983 to pay OOP. Ms. Black feels HDHP plans do not work best for Connecticut residents.

Tom Lally – Connecticut Education Association, Insurance Specialist

- Primarily working to assist negotiating employee benefits on behalf of municipal board of educations (BOE). More than half have HDHPs and all of them have HSAs except for people who are ineligible because Tricare or VA coverage. Some BOEs have no deductible funding but do have a premium share.
- One of the driving forces behind rise of HDHPs was excess tax of ACA. When first introduced, deductibles were relatively low.
- Rhetorical question – a lot of great conversation here, but recommend talking with someone from CID about what they can't do around self-insurance and especially municipal ERISA-exempt plans. Regulating HDHPs is a small number of insured people in CT. Recommend talk to someone from CID.

Questions:

- **Janice Perkins:** Asked for clarification on what he does; Tom works with locals as they steer and negotiate insurance and employee benefits of their contract more than half of BOE have HDHPs. Do most have HSA's? Tom answers, yes all of them do; the only time HRA's (Health Reimbursement Arrangements) come into play is if someone is ineligible due to Tricare or VA, in which case they provide an HRA that's funded the same. Some BOE's have no deductible funding but the trade-off is premium share. Janice agrees with suggestion of CID coming to talk to us.
- Halpin: what is percent of members on BOE's that contribute to that deductible to the HSAs and do they fund a portion of the deductible through the HSA. Tom states that about 90% contribute to the deductible who fund HSA or fund deductible. You trend claims and the more you can get funds out of claims the more you can lower costs.
- **Janice:** you guys provide education to members on how to use benefit. Any ideas about what works and doesn't? Is this done just at enrollment? Through the year? Tom: Does engagement throughout the year. Heading out after this to talk to people approaching 65 years old and wanting to know if they have to enroll in part A – they can continue to fund HSA if not enrolled in Part A. At contract ratifications Tom has 1.5-2 hours to do a presentation to walk people through a HDHP vs. a typical co-pay plan. He walks people through process of how to negotiate with providers, how to use pharma benefit, how to use any discount or smart-shopper programs, pricing tools. In a lot of cases, small local pharmacies can beat the big guys and that is counterintuitive. Can you price-shop your scheduled care? Most people don't but they can with the right tools. Tom applauds the ACA but the excise tax did drive bargaining. Cost of insuring people in CT, especially Fairfield County, is the highest in the country.
- **Susan:** Thank you for coming forward. A lot of people have come to her and other members and expressed their concerns and frustrations.
- **Bob:** what's been the experience since the introduction of HDHPs in the teachers bargaining with regard to overall premium cost since intro of HDHPs, and cost-shares over time. What's your experience with co-shares over time and your experience with the nature of the deductible they have to pay?

- Tom: When HDHPs first came out, the decrement or relativity, where Employer has first dollar, other than \$20, \$30 or 40 copays, led to a difference between plan cost for non-HDHP vs. HDHP plans of almost 30%-35%. Plans hedged bets against excise. As claims cost and cost of doing business increased, the initially wide difference between two plan designs has closed. The gap is smaller statewide. The idea behind the HDHP is that the cost to have the insurance (premium) and the cost to use it (exposure to the deductible) should be less than just the cost of the copay plan. But the gap here has closed. Everything that people were afraid of, three contracts ago – what happens in negotiations. Raise costs, raise deductibles. When HDHPs were first introduced, they were \$1500 individual/\$3000 2 person family, but have grown and grown. Municipalities now typically have \$3000/\$6000 deductibles. Most places also have introduced post-deductible exposure. After reaching deductible, still have coinsurance (though rare in municipal market) and drug copays to another max after reaching deductible.
- **Joseph:** Initially the premium differential between has/HDHP plan and standard plan was enough to fully fund HSA. Made sense. May make sense comparing HSA plan to non-deductible plan which are only platinum. But the silver plan deductible 5 years ago has gone up 65% and it is still a silver plan. Max out of Pocket gone up 25%. The strange thing is that the AV (Actuarial Value) of that plan 5 years ago still meets the criteria as it did 5 years ago and now that much more expensive. Tom agrees and unfortunately those plans that do have deductibles, it may not apply to office visits, or specialists visits, or it does not for ER, pharmacy, inpatient where true cost really is, sometimes lab work and regrettably, those plans cannot qualify as HSA plans.

### **Committee Member Discussion on Recommendations Regarding Report to Legislature**

Ted:

- Feedback great and thoughtful;
- Appreciated Seth Powers format
- OHA in process of putting together a table which will include red-yellow-green ranking and capture individual thoughts; may call members if needed.
- Number 2.5 to be discussed at future meeting, at the choice of the panel.
  - **Susan** – we should have CID weigh in on this at least, and potentially a broader range of issues/recommendations.
- Powers – is DOI the proper authority or should it be the IRS or someone else? Halpin: good question. Sue responds not sure, but CID may be just a good first place to ask.
- Clarity on finding F – Ted reads the finding, which states that the incentives to insurers and providers are not optimally aligned to promote the containment of cost growth and improvement of quality and value
- **Bob** – concern about incentives for provider and insurers, needs to understand what these are and missing from the equation is consumer and payors; doesn't feel they are aligned either. What are these incentives and why aren't they aligned. This is not a broad enough comment. If listed as a finding would like it be more explicit before the committee accepts it. Adam spoke some on how he remembers this being pointed out to the group but will review prior meetings and presentations to flesh out this point. The finding may have originated from Jamie Stirling's presentation, and his point that for ACA-qualified plans, the operation of the MLR (Medical Loss Ratio) limits the amount of premium dollars that a carrier can keep for overhead and profit. They now need to spend 80% – 85% on paying claims. In order to make more money, driving down utilization is not available to them anymore. To expand that, if the plans are allowed to retain 15%-20% of the premium dollar, if the overall cost of care grows, this expands the number of dollars in that 15%-20% of the premium dollar the insurer can retain, thus possibly limiting the carriers' incentive to cut back on the overall cost of care.

- Susan – When I look at this and talk about the intent in our discussions I think it leads to what is happening to the industry at large. Maybe looking at global payments to providers based on quality outcomes and instead of fee for services where the more you see someone the more you make. How do we insure the money is going where it should be, focusing on primary care. Would like the findings to reflect a more positive tone.
- Dr. Freess feels the wording should be more accurate for example incentives of all stakeholders in the healthcare landscape need to be better aligned.
- Dr. Shangold – comments on finding D, doesn't agree with statement feels it should be worded differently by leaving out the word deductibles.
- Susan disagrees with previous comment; concerns about how we are tackling what is in front of us. Susan found going through this a challenging exercise, feels we need more structure; is this the report. Ted says this is not considered the report. Adam states that the legislature calls for this body to come up with findings and recommendations. This is how we came up with this. Took a broad look as possible at the record of discussions and presented.
- Susan feels going forward we're missing context on which of these things go into the frame work before I feel comfortable agreeing or not.
- Janice agrees with Susan's comments, we've looked at this so many times already. Feels a different outline from OHA would help move this along.
- Bob feels the reference to the 7 statutory factors, come to a format of what phrases relate to the statute. Ted feels maybe we should consider organizing the document based on the 7 factors.
- Seth feels we should just tackle this as is as we only have 5 more hours of meetings.

### **Health Literacy and Education**

- **1.1 Establish public-private partnerships to improve health insurance literacy**
  - Dr. Shangold – Villagra's presentation shows a deficit in healthcare education and there may be potential here. First public speaker today was surprised she did not have health coverage and the details were all a surprise. There are expensive lessons here and the State may be able to educate people ahead of time.
  - Seth – some sort of evidence needed to show that the interventions that we are supporting are shown to improve outcomes. Particularly in the area of health education. Thinking of pilot programs to show A/B differences. Feels this is missing from the recommendations. Maybe some pilot interventions, look at other states, comparing their experience or success vs our success.
  - Dr. Shangold would look at Villagra's studies showing where this is going well. In some ways we are inventing the wheel here but we should look into literature showing the best sense of success and if not, a pilot is a good way to try solving these things. In medicine, sometimes there are A B C recommendations.  
  
Halpin – restating for record that silence is not assent. Thinks that having an evidence-based piece to these recommendations makes a lot of sense. Would also add that as we are looking at this, it should not add to underlying cost of care. Assessments added to fund public programs or ideas are passed along to consumers and employers and that is an underlying premiums that we should proceed with and does not add to the escalating cost of health/premiums.
- **1.2 Increase Funding for health plan navigators**
  - **Susan** – her prior comments apply to whole category here, not just the first bullet.

- **Janice** – obviously support navigators but where is the money going to come from? What are we thinking there? Ted agrees this recommendation does not specify where to find the funding. Not sure that it is the charge of this Task Force to specify funding sources.
- **Susan** – change wording to explore increased funding rather than increase funding. So that they can look at the assessment of what is value.
- **Janice** – not to belabor the structure but if we are going to be listing things like this we need to provide context. This is one way to educate people but it needs to be explained in context. Ted states that OHA is are trying to be supportive of the Task Force, not directive; this document is based on what came up in presentations and discussions, and is not OHA's position. OHA, like other organizations represented at the table, may well have its own comments and recommendations after the Task Force, and separate from the Task Force's conclusions or recommendations.
- **Seth** – 1.2 sticks out because it's the only one that specifies increasing funding. Focus on what we are trying to achieve rather than the means by which it is to be achieved that's better to hand off in this reports
- **Dr. Freess** – we do have some latitude as non-legislatures to be a little aspirational but doesn't think the funding term is necessarily required here and we could just call for increased access to Navigators.
- **Joseph** – The navigators is at a particular stage, early in the enrollment process. I get phone calls constantly throughout the life of a plan year. Agrees that "increased access" makes more sense. The fact is that when someone is at the point of choosing the plan, AHCT always says "we can't advise you. You need a broker." They don't direct to a navigator but to a broker. Not calling for increased compensation for brokers, so also doesn't think increased funding for Navigators is necessary.
- 1.3 – Improve transparency
  - **Susan** – appreciate aspirational goal but should not duplicate ongoing efforts. Transparency is not a new issue there are lots of work groups and so on. We should not duplicate these efforts and should allow a chance for what has already passed to work.
  - **Dr. Shangold** – Agree w/ Halpin. In general, wouldn't want to push thing that further interferes with doctor/patient relationship. This must be focused on patient healing and well-being. Physician getting more involved in billing, which is not helpful for this relationship.
  - **Seth** – Reason late was trying to help someone with MRI cost quote. Feels a value of a recommendation of this committee In recognition of efforts ongoing, "continue to support efforts to improving transparency ..."
  - **Janice** – that is the right approach. OHS just launched a new tool, the cost estimator, regarding this and we should at least reference this.
- 1.4 – improve presentation of total costs in all areas of State healthcare coverage
  - **Ted**: AHCT increasingly trying to provide some of these tools but there is a way still to go. Personally would like to get to where you can shop around for a plan by having your personal claims examined so if you had that exact year again with same plan and providers, you'd pay X amount for the year.
  - **Joseph** – agrees with that. AHCT does a decent job but focuses on max costs but not who is paying when. It is difficult for individuals to figure that out.
  - **Ted** – the term AV can be deceptive to consumer and there is a better way to get to where consumers can understand their own likely individual exposure – try to estimate total costs for that family, i.e., premium plus all out of pocket responsibility. The AV metric has its place, which is on the plan side and not the consumer side. This measure was not meant for consumer but for plans and their financial needs. We need a better all-in cost estimate for health insurance plan consumers before they make their final plan selection.

- **Seth** – would be highly supportive of Ted’s idea
  - Economically dominated plans (Villagra) where there can never be a benefit to a particular plan over another one.
  - Study how many of economically dominated plans were selected and some sort of notification information within the system that denotes of which plans are economically dominated at the point of purchase.
  - Ted – will potentially add that. Trying to gauge level of support
- 1.5 – quarterly notices to members reminding them of the availability of pre-deductible preventive services
  - **Susan** – feels wording needs to be rephrased. Something to the effect of “enhance education regarding coverage for pre-deductible preventive services.” Consumer already gets a lot of notices. Lots of required state information. Ways to reduce administrative costs, and protect the consumer, who receives too much confusing paperwork.
  - **Janice** – Not sure who is giving the quarterly notices – is this providers, payors, the State. Written? Electronic, during a visit? When on the phone with carrier? Totally supports encouraging people to increase their awareness of pre-deductible services.
  - **Seth** – this is an opportunity for a pilot education with some different options.
  - **Bob** – assume reason on here is because not enough people are using preventive services. The real questions is why aren’t they and who are they? Goal is for them to use the preventive services? Because they are free. Is it education/notification or is there a carrot needed? See Dr. Fendrick’s presentation on VBID, high-value vs. low-value services. Premium goes up with lack of engagement with preventive services? Other incentive? Refers to State HEP (Health Enhancement Program, the wellness program for state employees), premium or deductible goes up when you don’t use the services. Feels this topic is getting at the utilization of these services and maybe the notice is not enough. How do we get people to complete those services? Rethink the safety net zone. Maybe a reward for those who complete those services.
  - **Freess** – don’t want to lose good for perfect. If the concept is good, we should consider endorsing it even if we do not have the perfect implementation with all details.
  - **Cassandra Murphy** – many people don’t realize preventive services are free. A lot of her members don’t read their mail. Room for more education on this scope. Maybe an electronic push on this.
  - **Dr. Shangold** – should switch language from “free” to “included”. A lot comes down to whether a service is coded as preventive. So it can be hard to say ahead of a visit that a treatment will be coded as preventive.

## HSA Section

- 3.1 – allow Medicare eligible members to continue contributing to HSAs.
  - **Ted** – this is a good example of one the state probably can’t accomplish but can recommend to Feds. When you reach Medicare age you can’t contribute to an HSA
  - **Joseph** states enrolled in Part A can’t contribute. If enrolled in Employer-sponsored plan that is creditable coverage, can contribute to HSA after 65. Can waive at 65 as long as you are covered by an employer sponsored plan.
  - **Seth** – Is the idea to include these but refer these to the Federal level? Ted answers his instinct would be to explain in report that the state does not have authority but can refer issue/recommendation to the state’s federal delegation with a recommendation to push for change at the federal level.
  - **Janice** - important to note some of the positive things about HSAs and even a statement around encouraging the legislature not to run afoul of HSA requirements established by the IRS. Would really like to see such a statement in the report. Ted – so for clarification identifying what is in the state vs. federal purview. Janice – yes, and also not run afoul of the HSA rules.

- **Joseph** – Not sure how we could break this. Understands there is legislation to expand eligibility. Has a problem with this whole section as we have no jurisdiction over it.  
**Janice** – have been proposals that would recommend a service being classified as a preventative services that would not be compatible with the IRS regulations. Would like it to be explicit. Ted states that not all of section 3 is out of bounds for the state to make recommendations or issue new regulations or statutes.
- **Dr. Freess** – statement that there are things that we can't effect because they are not compatible with IRS rules but we can say some IRS rules are not necessarily helping citizens.
- **Susan** – how these are articulated in a report is going to make difference on whether we support or oppose.
- **Seth** – We heard that there is a part of population that HSAs are really beneficial for. Worth including those folks and evidence as well as the people they don't work for.
- **Dr. Shangold** – if we are going to exclude things from the report because we are drawing a line around IRS rules, that may be binding us too much. We may be able to recommend things in areas where IRS rules are not clear or should be changed. We are in an aspirational role.
- **Ted** – the legislature has staff who are well versed in federal preemption. Nothing will slip through by mistake. If this Task Force sees things that should be changed or improved, we should tell the General Assembly, with an appropriate heads-up for things that are obviously outside the state's own jurisdiction, and best directed to the federal level.
- 3.2 Allow spouses to make HSA catch-up contributions above current allowable limits
  - **Ted** feels a lot of considerations in item one probably apply to this item as well
  - **Joseph** agrees with that HSAs are individual accounts. When you are 55 if working spouse has an HSA that covers dependents, employee can do catchup but you could set up two accounts one for employee and one dependent, but thinks this is a stupid way to do this.
- 3.3 – Redefine HSA eligibility on the basis of Metal tiering levels
  - **Ted** not sure what is indicated here. Does this mean all bronze plans would be HSA eligible, needs some clarification
  - **Joseph** – thinks it has to do with AHCT cannot create an HSA-compatible plan at the silver level because that would interfere with cost sharing. If you eliminate the metal tiering this could work, but actually you can't get rid of the metal tiers as they are a requirement of the ACA
  - **Susan** – Might behoove us to change the word to explore, as a recommendation.
- 3.4 require AHCT to explore and if legally permissible require only HSA-compatible plans HDHP plans
  - **Seth** – reviewed AHCT Portable, concerned because some HD plans that qualify based on how high the premium is but there first dollar coverage there may be co-payment options available vs. having consumer responsible for all costs as under an HSA plan. Feels these terms are being used interchangeably.
  - **Janice** – consumer choice is important and there is a lot of more flexibility in plan design outside of the HSA-compatible space.
  - **Joseph** – Bronze standard plan allows 3 categories not subject to the deductible, urgent care, primary care doctor visit, generic prescriptions. Feels plenty of people will not put money into an HSA as they are healthy and just want to be able to see their provider if they get the flu or feel ill, eliminating these plans would be counterproductive.
  - **Seth** – only one plan on the state exchange is HSA-compatible. Maybe this is an opportunity to explore creating more HSA plans

- **Joseph** – impossible to create one within HSA parameters that is appreciably different to what is already available. CSRs (federal Cost Sharing Reduction payments) are a problem. All silvers have to be CSR compatible but that makes them not HSA-compatible. Maybe this should be called out in this report. Seth asks what about gold plans? Is this possible in the small market. Janice says maybe. Susan reminds members to be careful of unintended consequences. Have to rely on bodies that have already built the expertise. Maybe ask them to make recommendations to the Feds that they would like to see changed. Ted learned from ABA that HSA-eligible plans are more efficient at driving consumer choice, raises the question on whether they should be encouraged.
- **Dr. Shangold** – more choice is better in general. Getting back to health education and literacy having more navigators is better.
- **Ted** – Dr. Villagra would say that more choice is not an unmixed blessing as it can stymie consumers from making educated choices. Simplifying choices is better for the consumer. Seth asks is there a nuance between having the plans available and having them displayed? (Steering issue?). Ted – AHCT does at times suppress choices that are deemed inappropriate for a particular consumer; the choices are there but the customer has to drill down a bit to uncover them.
- **Bob** – refers to Ann Lopes' comments concluded with statement that offering only HSAs is contrary to AHCT's mission. Is that accurate? Can we push back a little bit about that? Is value restricted by HAS compatible plans?
- 3.5 – Allow consumers to direct tax refund to HSA account instead of a personal bank account
  - **Seth** – thought these next couple are great ideas that could easily be implemented.
  - **Ted** – talk to DOI about this and their take on it
  - **Dr. Shangold** – this and 3.6 anything that helps fund the HSAs is a good thing for the people who have them. Probably earlier in the year rather than later because of catastrophic events that can domino

### Other Business

- Ted asks members when they would like to discuss 2.5. Janice asks if we should we wait until we hear from CID or other authority. Dr. Shangold – this is aspirational and has been brought in many other states. We can debate it on the merits. This is a barrier to care and we do need to find a solution. Wants to do it next Friday. Sue asks for a review of the meeting dates. Ted asks Sherri to provide future dates. Decision made to discuss section 2.5 at the January 28, 2020 meeting.

**McDonagh** – Regarding HSAs there was a point in the original materials that IRS had listed some care that could be considered preventive but not mandated, just recommended. We might want to include this in our recommendations that we encourage carriers and AHCT to consider adding those.

Next meeting will be held on  
January 17, 2020  
11:00 AM – 1:00 PM  
Room LOB Room 2D