

**HDHP Task Force
January 28, 2020
11:00 AM – 1:00 PM
Legislative Office Building, Room 2D**

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

OHA Staff Present: Adam Prizio, Sean King, Sherri Koss

Welcome

- Ted opens meeting at 11:01 AM

Roll Call

- Cassandra Murphy (via phone)
- Dr. Daniel Freess
- Dr. Gregory Shangold
- Robert Krzys
- Seth Powers
- Ted Doolittle
- Susan Halpin
- Janice Perkins
- Pat McCabe
- Dr. Andrew Lim (joined at 11:06 AM)
- Joseph McDonagh
- Dr. Andrew Wormser

Approval of Agenda

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

Approval of 1/17/20 Minutes

- Ted asks for motion to discuss or approve minutes, Dr. Gregory Shangold motioned to approve and Janice Perkins seconded; Dr. Wormser commented that all abbreviations should be spelled out and then abbreviated so everyone knows what they mean (i.e. Connecticut Insurance Department, CID, and OHA (Office of the Healthcare Advocate)). Ted agrees, no nays, no abstentions, motion carries unanimously to approve

Paul Lombardo, Director of Life & Health Division at the Connecticut Insurance Department

- Mr. Paul Lombardo who has expertise on many matters this panel is considering. Response in writing distributed
- Sue asks for Paul to summarize comments

- General comment was, Ted had forwarded the questions that had come from Task Force looking for technical responses. Some items don't have exact answers because there is a need to seek responses from some Federal agencies
- Health carriers now have the option to offer additional 14 items at first-dollar coverage as a result of a change contained in Internal Revenue Service (IRS) Notice 2019-45. Right now these new services are not required to be offered as first dollar but they are optional. The first question posed by the Task Force was, what if CT mandated the optional 14 items? The effects on subsidized and non-subsidized markets, there would be increase in premiums for HDHPs (High Deductible Health Plans) and potential impact to actuarial value (AV) calculator which would potentially impact metal tiering, which is required by the Affordable Care Act (ACA). The more benefits that you change cost sharing on, the more potential you have to go out of the required AV range for metal tier. Carriers will have to recalculate and re-evaluate mental health parity and substance abuse parity because as you change cost share for certain benefits they have to rerun their certification to make sure to preserve parity.
- Dr. Wormser –when calculating any increase of premiums needed if the 14 items are mandated, do we take into account the potential for health benefit here of adding those categories?
- Paul - there is always a potential improvement in health from mandating coverage of certain services, but we would expect the dividends from improvement of health to come over time. Would estimate the initial impact on premiums that could come through claims; this would mean lower cost sharing to the individual, but higher medical claims amounts paid by the carrier. To consider health improvements from including new services, we would need to project those savings over time. But CID (Connecticut Insurance Department) only approves rates for one year, we would expect any improved health to come through the claims over a period of time, so it is difficult to take any health improvements into account in the rates for a given year.
- Second question from Task Force – mandating first-dollar coverage of mental health and behavioral health coverages. There is an understanding that mandating first-dollar coverage of mental health services would require Federal action concerning the HSA. Paul was on the call with IRS where the 2019-45 was announced and the notice is clear that the named items are the only preventive/chronic care items allowed under this expansion. The question was asked of the IRS in that call, could carriers include other items besides the 14 items and it was an unequivocal no.
- If we applied first dollar coverage of the 14 new IRS items for non-HSA plans, that could be done without running afoul of the federal rules that apply to HSA plans, but you'd see an increase in premiums to cover those benefits. Future health improvements would be reflected in diminished claims over a period of years. Same issue with potential recalculation and metal tiering issues as item 1. There is something called reverse mental health and substance abuse parity. Feds have taken position that you can't have just mental health-substance abuse benefits at first dollar coverage and all other categories at copay/coinsurance.
- Seth – who is pricing longitudinal benefits into insurance, if it's not CID?
- Paul - only looking at rate filings on a yearly basis. Longitudinal benefits - don't have access to the data can't be included in those rate filings. Only look at most recent claim experience and unit cost/utilization estimates for next year. So you can only price these longitudinal effects in as they show up in last year's claims data. Connecticut Insurance Department doesn't get a utilization breakdown that granular. They only get "inpatient, outpatient, physician, pharmacy". Would have to try to assess if there were any movement in other states that may have had something passed 4 or 5 years ago – but Paul not aware of any.
- This describes the problem of the commons – the people who can directly improve the general health do not get to price in the benefits of that improvement.

- Susan – rates do go to CID for analysis which is often lost in the discussion. Could you describe the rate review process? Clarify that these rates are not set by the carriers.
- Paul - at high level, all individual, small employer, and HMO large group but not large group indemnity, plans have to file and reviewed from actuarial perspective. Process very defined. Analysis, questions and communications are all public. Transparent through the process. ACA filings for individual and small group come in July. They are posted online. All communications in real time. Contain unit cost and utilization information over usually a 3 year period. Pharmacy broken out from medical. These are on the website. Happy to help people find and review these rate filings. Decisions and full analysis posted on the website in September. Also shows disagreements with the carriers, and CID's rationale for any rulings different from carriers' own estimates.
- Ted – following up on Seth's point, are there any models in other states, or legal or technical barriers, to multi-year rate filings to capture longitudinal savings?
- Paul - Yes there are barriers. Carriers must file on annual basis. Rates only good for one year in the individual and small group as well as large group market.
- Large group indemnity carriers may offer multi-year rates but CID doesn't review rates for those plans. They are credibility weighted and use some, if not all, of the experience of large employers on a fully insured basis and they do not have to file with CID, and neither do self-funded or stop loss plans. Not aware of any other states using a multi-year rate filing process.
- Ted – interesting that there is a focus on wellness in the marketplace, but the one year limit cuts at cross purposes because the long-term benefits cannot be taken into account, only the short-term costs.
- Task Force question 3. The way it is now, consumers reimburse the doctor up to the deductible amount. If it were required that the carriers reimburse physicians for all claims incurred regardless of deductible status, and then have the member pay carriers back for the deductible that they owe, what would the potential issues be? This would require an IRS ruling, with regard to affecting the tax qualified status of an HSA plan vs non-HSA HDHP. Would not run afoul on non-HSA. This is a watch out item.
- Connecticut Insurance Department doesn't work for carriers and doesn't know how their IT systems are set up but guesses that this is a big administrative/IT lift and likely to increase the costs, to the extent if they could not collect all of the deductible owed from members, that would impact claims and medical losses which would have impact on premiums, but doesn't know the extent. Not aware of any state that has this at present so not able to confer with them to identify the impact.
- Ted – Debate on this in a few minutes, but if you have questions for Paul, now is the time to ask
- Perkins – regarding item 3, is the National Association Insurance Commissioners (NAIC) contemplating any action on this? Paul - Not aware of any.

Public Comment

- None at this time

Section 2 Cost Sharing Reforms

- 2.5 Carriers are responsible for paying cost shares to providers and collecting those payments from their insureds
 - Dr. Freess – thinks this helps consumers on multiple fronts. We've discussed how when people get into debt with doctors that has adverse effects on care. Sees this multiple times a week – not because been kicked out, but because owe money. Think relationship between carriers are different than the doctor-patient relationship, which is harmed by HDHPs.
 - System is pushing people into HDHPs because premiums are high. Dr. Freess compares it to subprime mortgage lending crisis. Mortgage lenders were giving mortgages to people who couldn't afford and were not clearing them, then rolling the credit risk off to others. As in this case, people can't afford what they purchased. Thinks this change could align the incentives in a better way.

- Ms. Perkins – Think this is one of those issues that can be fraught with unintended consequences. If someone doesn't pay premium they have a grace period through AHCT. Don't know how this would fit into that – if someone has a deductible that is outstanding to the carrier for several months, would that result in disenrollment?
- Second thing – don't think this is a clear consensus proposal and should not be included in report as a consensus recommendation.
- Mr. Powers – Think about the benefits to consumers - smaller provider groups don't have economies of scale that large carriers do to go after outstanding balances. The relative cost to small organizations is different. Agrees with Dr. Freess about barriers to care.
- Dr. Shangold – refers to Legal Opinion that Connecticut State Medical Society earlier provided to the Task Force – analogy to a patient paying with credit card, and then reimbursing themselves via HSA reimbursement. Here we have intended consequences – all of the things that could be problems for carriers are things that providers are bearing now. There is a significant amount of bad debt and that might be why costs are going up. Studies show that is about 50%. Time to collect for small businesses can be a long time, especially on a payment plan. That time to collect is very different to a carrier. Physicians and providers have had to incur just the same costs that carriers would have to incur in order to collect. Paul suggested that carriers would have to change their infrastructure to be debt collectors, but providers have had to do this already, huge investment and cost in those efforts to collect.
- Ted – quick question. Directed to providers – would you see any price reduction for services if this were to go into effect?
- Dr. Freess – not able to answer for whole community but would expect that physicians would accept a lower rate/fee schedule with better guarantee of payment. Other benefit is simplicity in billing to patient, rather than getting a bill, then an EOB, then a later bill, then whatever else. It is confusing even to sophisticated consumers.
- Mr. McCabe – costs are complex and include subsidization of underfunded governmental programs as well as cost of collections relative to these services, built into the formulas. Any reduction in those costs should lead to a reduction in prices. Two issues relative to this – would love to get out of business of having to collect rates that I've already negotiated. Would love to not pursue patients about it. Not sure it does anything to address deductibles immediately. Maybe downstream effects, but not immediate. Doesn't provide immediate relief or benefit to HDHP members. Also concerned about unknown consequences – will this lead to more patients being uninsured and therefore more burden to those patients financially and therefore more bad debt, therefore pricing concessions go away.
- Mr. Powers – Another leg to the question – would payers be willing to pay more for not having to assume that debt? Who's willing to take on that risk?
- Mr. McDonagh - Find this very difficult to support in part because it's just shifting responsibilities for collecting. Cost-sharing is the euphemism. Transferring the costs to insurer is attractive. Appreciate the doctor-patient relationship issues that have been raised. Question was raised: if individual misses premium they will be terminated. Will they be terminated for not paying deductible? May not have impact on deductibles but will definitely have impact on premium. Hate to be defender of carriers but they have a relatively small margin. Does this become a part of increased administrative cost? Doesn't want carriers to be saying they can't do business in Connecticut
- Mr. McCabe – providers also have a small margin in this state. This is a circular error issue because the providers, when they sit across the table, they are calculating into the rates the bad debt burden which increases the prices which lead to higher deductibles which increase bad debt burden and so on.

- Dr. Shangold –We haven't talked about eliminating cost sharing. Patient still has the same responsibility, just to who the payment goes to. Right now working under assumption that bad debt assumed by providers is baked into the cost of health care. Saying that savings already exists. But this is not sustainable. If you go for the past 10 years, the amount that we collect per encounter is complex. The commercial payer market share varies for different provider, but is a small amount compared to Medicare, Medicaid, and self-pay. Still using 2011 fee schedule for Medicaid. Affordable Care Act (ACA) made a dent of 1%-2% for uninsured. Uninsured still about 5%-10%. There's been an absolute reduction in the payment per visit that providers get. I haven't seen where the insurance companies are reporting negative profit, but providers are struggling. Also, it might make it easier to join a network because you know you are going to get paid. Feels it is likely that this change would lead to good unintended consequences
- Ms. Halpin – Thinks this single issue has really been the undercurrent of much task force activity. Think people already know how they feel on this issue. The discussion has only underscored the complexities and the potential for unintended consequences. But bad debt is already negotiated on the table between providers and carriers. Not sure legal opinions are going to sway anybody. Agrees with Ms. Perkins this should be removed from report. What would the next step on this, but if it continues we would issue a minority report.
- 2.1 – Phase out HDHPs and co-insurance and shift toward copayments and potentially shift toward VBID (Value-Based Insurance Design)
 - Mr. McCabe – to me this is just shuffling the deck chairs on the Titanic. Changing form from high deductible to high copay. Think if we made a recommendation to focus on plan design that focused more on the VBID component, that would be a worthwhile recommendation and longer term may have an effect on healthcare. Shifting from co-insurance to copay doesn't change the economic issue just changes the form.
 - Dr. Freess – Agree with Pat McCabe. Would be in favor of more targeted use of high deductibles with deference to people's ability to pay deductibles. Ted – saying should be some sort of cost / income analysis to determine whether an individual is financially suited to or eligible to buy an HDHP. Dr. Freess – yes. Phase out for certain class of people.
 - Mr. McDonagh – would simplify by eliminating all but platinum in individual market. Couldn't do it in marketplace because of Actuarial Value metal levels. There is not a lot of room to insert VBID concepts into the market, due to AV and other restrictions. Pointed out no bronze plan can exist that provides pre-deductible coverage for specialists due to the AV restrictions on bronze. So any such requirement cannot apply to Access Health CT (AHCT). Doesn't feel this is realistic.
 - Ms. Halpin – could Pat restate what he suggesting. I think I liked it.
 - McCabe – I think essentially was indicating that this should recommend that insurance design should center around VBID which would down the road lead to reduction in costs and potentially also premiums. Mr. Doolittle asks what would the instruction to the carriers be? Pat McCabe - The task Force recommends a pairing of VBID incentive design component into insurance plans that carry high deductibles. Ted Doolittle – a statute? A regulation? Mr. McCabe would recommend that.
 - Mr. Powers – the hasty elimination of HDHPs would surely skyrocket premiums and have unintended consequences. But let's talk coinsurance. That is a challenging area for consumers. Coinsurance is hard for consumers to plan for. Limiting or capping coinsurance might be a valuable exercise. Looking at what Dr. Villagra said about looking at how much time people spend in the coinsurance band get accessed by consumer before they hit their out of pocket max, there may be some fruitful beneficial trade-off.

- 2.2 – Tie Cost Sharing to Family Income
 - Somewhat similar to what Dr. Freess referred to.
 - Ms. Perkins – Obviously this gets to affordability issue which is important. Not sure what impact would be on premiums or rest of plan design. Thinks the work of OHS (state Office of Health Strategy) on affordability is something we should all be watching. Standing alone, don't know what it means.
 - Dr. Shangold – Agree with Janice Perkins. If this work is already being done somewhere else maybe we should focus more on the things that haven't been looked at
 - Mr. Krzys – Regarding recommendation 4.1, establishing an affordability metric. Question came up about whether affordability metric was a finding or a recommendation. Want to throw out that it should be both. Suggest we find something – the work of OHS to establish an affordability metric is highly important to the state of CT – and recommend that the affordability metric that currently exists to be modified by OHS be matched to the level of cost of a HDHP. You can go to affordability metric and see whether their health plan matches the affordability metric for a particular family in a particular area.
 - Ms. Halpin – Thinks it is much more complex than it appears on paper and add that she finds it concerning.
- 2.3 – Allow pro-rating of deductibles for new enrollees in middle of a plan year.
 - Ms. Halpin – repeat of previous comments.
 - Dr. Shangold – group hires a lot of residents who join in middle of year. Many people don't start their jobs on Jan 1. This seems to make sense. Don't know if there's an argument on the dollars and cents but presumably if they are covering the risk and the deductible is not adjusted, this would seem unfair.
 - Dr. Wormser – this might assist with job portability.
 - Dr. Freess – seems intuitive and fair
 - Mr. McCabe – want to talk about the complexity relative to this. Not all plans are on a calendar year. Moving from one employer to another you may have a different fiscal year. It seems like it may make sense but may be fairly complex.
 - Ms. Halpin – Just to build on this you are mixing markets, employers, health plans, and all different components of the way that premiums are determined. The rate-setting process that health plans need to go through. I can see the appeal of this on its face, it should be intuitive but I don't think it works in practical terms.
 - Dr. Shangold – Think we are combining 2.3 and 2.4 in some of this discussion. Of the plan you're going into, whatever the plan that's receiving you is, they have to pro-rate the deductible. Has nothing to do with where you come from, i.e. nothing to do with the nature of the prior plan.
 - Mr. McDonagh - This goes not just to the deductible but, are we also adjusting the maximum out of pocket (MOOP)? Again, this is aspirational, a lovely thought. I have a map of the year and most of my clients don't have a January to December plan year. Does impact employee job mobility.
 - Ms. Perkins – not sure, say for instance you have HSA. If you start in July do you run afoul of being in an HSA-compatible plan, if it's not the full deductible amount Ted responds he was under the impression nothing we do can would impact an HSA eligible plan from a state, either regulatory or legal perspective. Sean King, counsel for OHA, states we can carve out any recommendations that would not apply to HSA compatible plans.
- 2.4 – Credit for last plan's deductible after switching plans
 - Dr. Freess – was going to be a pro on it with little knowledge of what are likely to be a litany of very good reasons it can't happen. The current system is inherently unfair and in the end I think our goal has to be to resolve the situation.

- 2.6 – Documented oral advice given by carrier Customer Service Representatives (CSRs) should take precedence over contrary plan terms.
 - Office of the Healthcare Advocate (OHA) commonly sees situations where a consumer has called a Consumer Service Representative (CSR) and been told a treatment is covered but then gets a denial and the plan terms govern.
 - Mr. Powers – the unintended consequences could be a real problem here. If you look at the folks that are filling CSR positions they are not attorneys. You'd see plans just sending people to the plan doc and not answering questions any more over the phone. Feels this could be a much worse customer service experience. Could we have a centralized documentation when these errors occur and have reports disclosing this information.
 - Dr. Wormser – change default position which is currently that written rules trump given advice. What if it should go to some form of adjudication rather than just the consumer losing? A way of judging the decision-making process without just giving them the win would be to put it to arbitration.
 - Ms. Perkins – also have to file member contracts and handbooks for department to review along with rate filings. We all go by what is in the member contract. Connecticut has a rigorous appeal process. Don't see how this proposal is workable. Already have an arbitration process and there is a lot of work that goes into the appeals. Thinks this is a slippery slope to take on.
 - Ms. Halpin – One of the roles of the Managed Care Ombudsman, which later became OHA, was to assist consumers who are having trouble navigating the grievance process. CID also has an actively engaged consumer assistance division that routinely reaches out to carriers if there are concerns. Think there are avenues in place to address these issues. This is a place where Connecticut took action early and has provided a model for the rest of the country.
 - Dr. Shangold – This is a complex issue but here is a personal story. Providers also do appeals. Was taking care of a 93-year old female patient who was undergoing outpatient workup due to losing weight, no appetite. Looking for CT scan. Getting weaker and weaker. CT scan denied. Finally got CT scan in ER. She had metastatic lung cancer. Emergency room had fewer hoops to jump through. We have to get patients to care at the right time.
- 2.7 – Incentives to encourage members to seek care early in the plan year, such as carriers allowing providers to waive collecting copay/co-insurance for primary care sought in the first quarter of the year.
 - Dr. Wormser – struggle in primary care to deal with HDHPs which incentivize people to race into office at end of year after deductible expires. This distorts care. Not clear that asking everybody to come in in the first quarter is the solution. The real problem is the deductibles and not sure this is a solution.
 - Mr. McDonagh - Had one question regarding section 4.2 from the draft report – not familiar with carriers trying to recoup from providers who have stopped trying to collect. Was at ER and was offered a discount for paying within 20 days. Does this happen in other areas?
 - Mr. Doolittle – Medicare has a coinsurance component and providers must not waive collecting that coinsurance and can get kicked out of the program if they do not pursue the coinsurance from Medicare patients.
 - Mr. Powers – I raised this issue and shared the same example last minute. This was a watch out item.
 - Ms. Perkins – I checked with our folks (i.e. ConnectiCare) and we don't do that. Since this sentence is maybe hearsay I think we should remove it. Carriers not surveyed.
 - Ms. Halpin – Think there are some sweeping statements that are not data-driven in the report and I think that is a mistake going forward. Don't think we should let the exception drive the rule. I am concerned about statements like this. I think it is a missed opportunity for educating people more broadly on HDHPs that sweeping statements lead people in a different direction.

- Mr. McCabe – Report says “final report” and there is language like “the task force was mixed on this” how are we going to put things like this into the final report. Will the recommendation and commentary of the mixed nature of the opinion would stay in the report? Would we reach a point where things would stay in the report?
- Mr. Doolittle – OHA is just staffing this and trying to reflect the pleasure of the task force. Anticipate another meeting, probably phone where we can revisit it at that time or continue now. This drafting is just to let everyone know where we had been on each issue

Section 5 Cost & Quality Control

- **5.1 Establish a medical cost trend cap or other cost growth limitations**
 - Mr. Doolittle stated that the Governor issued executive order (EO) to establish a medical trend benchmark by Office of Health Strategy. We should be cognizant of this.
 - Dr. Wormser – consider looking at 5.3 first.
 - Mr. McCabe – given EO, does this need to be in the report.
 - Ms. Halpin – majority of my notes are that these are out of scope for task force. And fraught with unintended consequences. Dangers when you talk about cap rather than target or goal.
 - Mr. Doolittle – your own comments say that cost and price are a real driver here so it’s interesting to me that cost-related measures are now out of scope.
 - Ms. Halpin – dangerous to take these recommendations singularly without looking at the whole. Maybe we support other ongoing efforts. Absolutely I think the costs of care are a primary driver of premiums and deductibles. Mr. Doolittle asks if Sue’s association taken a position on the Governor’s executive order. Ms. Halpin responds she thinks it’s an important dialogue to have and not sure what that form will take. Looking forward to further discussion.
 - Dr. Shangold – attention to a similar rule with sustainable growth rate which was basically a cap on Medicare. Every year I went to Washington to say this is a flawed formula. At last minute Congress released the cap. There was a formula that limited the amount physician rates, but every year it was waived, until finally recently the whole sustainable growth rate rule was taken out by statute.
- **5.3 Implement VBIDs**
 - 5.3.1 Establish means for evaluation of low vs high value care
 - 5.3.2 Require all fully insured HDHPs to cover all optional treatment.
 - Dr. Wormser in support of 5.3.2 - would like it to apply to all fully insured HDHPs. Have heard that people don’t know preventive care is covered. We need to get some kind of useful care outside of deductibles. IRS list not perfect but a good place to start. Initially increase in premiums but there might also be an improvement in health outcomes. Would like committee to take a bold step and get some useful care extended to patients that falls outside of the deductibles. If we don’t try something, we just don’t know.
 - Mr. Doolittle – reminds panel back to Mr. McKechnie testimony the State could not require HSA eligible plans to cover new list of IRS optional services
 - Ms. Perkins – support VBID designs and doing whatever we can to encourage employers to use them. Not sure how 5.3.2 belongs under VBID. Mr. Doolittle feels link may be VBID is specifically to make sure that high care incentivized and low value care de-incentivized.
 - Mr. McDonagh. Agree with Dr. Wormser – it would increase premiums but long term effect could be substantial. Suggest that language be changed to something like “require non-HSA and urge HSA plans” as it would be up to the plan itself and the insurance company
- **5.2 Establish rules align prices of healthcare services with actual costs.**
 - Mr. McCabe – this assumes that prices don’t align with actual costs. Providers already account for costs of production, uncompensated expenses, underpayment for government care, capital expenses, and so on. Only speaking for hospitals but would say the prices fairly align with costs.

- Ms. Perkins – agrees with Mr. McCabe but also think this could be one of the issues that can be coupled with Governor’s Executive Order on cost benchmarking. This is so vague. I think we could spend a whole meeting talking about defensive medicine or training clinicians. I don’t think this belongs in the report and will be addressed in benchmarking initiatives. Don’t think this belongs in report. And 5.2 will be addressed in some kind of medical benchmarking initiatives
- 5.7 Require copays and possibly coupons to count toward deductibles and OOP Max for non-HSA HDHPs
 - Mr. Powers – could somebody speak to the argument against this?
 - Ms. Halpin – When you look at this there are a number of issues tracking issues with the pharmacy how a coupon presents in the system and shows up, how verified, and so on. Administrative concerns. Some plans/carriers may already do this. Concern from a broader perspective is, does it work at cross purposes with trying to get people to use the less expensive generics.
 - Mr. Doolittle shares that this country and New Zealand only two countries in the world that allow of advertisements of these drugs on TV.
- 5.4 Promote performance-based goals for improvement within certain points reported on the Consumer Report Card
 - Ms. Perkins – Where did this come from? Consumer report card pretty detailed and we report to CID and wondering if you can provide some context
 - Mr. Doolittle – was this from Seth?
 - Mr. Powers – was looking for a centralized place where data lives that we could track over time. Not sure what this is aiming to get at? Sean King, OHA counsel, feels this came from some of Dr. Villagra’s comments and looking for metrics that measure those recommendations as a useful tool going forward
 - Dr. Shangold – Agree – whatever we recommend and implement, we should track performance of it. Should be in report to mandate some kind of metrics
 - Mr. Doolittle suggests setting up a phone meeting to give this a final review
 - Mr. Powers – questions what would be the easiest way to receive feedback on this report. Mr. King states we will send a word version of the document for the members to track changes and submit.
 - Mr. McCabe – there are still 3 bullets that we have not addressed. Think there is a fair amount of conversation on 5.8 as well as 5.5 and 5.6. Thinks phone meeting would be very difficult
- 5.8 Facilitate new entrants to health insurance marketplace including public option.
 - Mr. McCabe – more than amenable to new entrants but the public option portion is of significant concern. Vast majority of our cost shift is because of the underpayment of government health care programs. This will lead to a race to the bottom and underpayment and even further distort cost shifting.
 - Mr. Doolittle – new entrants to the marketplace are more than welcome especially in the AHCT marketplace. Always a concern of one of the carriers dropping from the exchange. Very open to public option
 - Ms. Halpin agrees with Pat McCabe and feels this is way out of scope. A public option will only exacerbate all of the concerns and challenges and issues that have been discussed around this table. What you’re talking about is reducing rates essentially rate-setting like Medicaid and Medicare. The result will be that the Fully Insured and Commercial market will pick up the difference. We would strongly oppose inclusion of public option. We are supportive of entrance of new options in the market but the way you do that is by allowing carriers to innovate. At beginning where we were talking about executive order that was bipartisan and supported by the legislature. Perfect example of folks coming to the table. For the record executive order was bi-partisan and supported by legislature as well. We would very much oppose 5.8 and don’t think it belongs in the report.

- Mr. Powers – important to recognize why this is a part of the conversation. Appreciate the reluctance to put the public option on the table, is how this is going to resolve unless we do something to fix these issues.
- Ms. Perkins -- Really think 5.5 and 5.6 are out of scope and remove them along with 5.8
- Dr. Shangold – Talked a lot about cost but to not talk about defensive medicine and costs of medical education is naïve. Obviously this is complex but these are a major driver of costs. I can tell you I do tests every day because of defensive medicine. I see new doctors with \$300k in debt from medical school – that drives costs too.
- Dr. Freess – losing forest for trees on 5.8 but don't want to lose facilitate new entrants in market. Think more support for that. Not so much for the public option and leave it out
- Mr. McDonagh - I personally support public option but also believe these three are out of scope.
- Ms. Halpin – think there were a couple of recommendations around the table. Remove “public option” and would like to know what approach is going to be regarding those. Where are we in terms of moving forward on the recommendations and the approach on those recommendations?
- Mr. Doolittle – we have been doing our best to assimilate these comments. Looking for more or stronger consensus. Ms. Halpin asks is it our intent to keep public option in the report. Mr. Doolittle asks if there is a consensus to delete the public option. Ms. Halpin wants to know purpose of next meeting. Mr. Doolittle: from the process standpoint, will incorporate Paul Lombardo's comments, and discussions from today into the draft and then we can have a discussion on process and decide what the final steps will be. A new draft will be issued for discussion at the last meeting
- Mr. Powers in person would be a better meeting vs over the phone

Other Business

- Suggested another meeting be scheduled next week

Mr. Doolittle asks for motion to adjourn the meeting. Joseph McDonagh motioned to adjourn and Susan Halpin seconded. Meeting adjourned by unanimous vote at 1:12 PM

Next meeting will be held on
Wednesday, February 5, 2020
11:00 AM – 1:00 PM
Room LOB Room 2D