Appendix J

Healthcare Affordability Standard Advisory Committee

January 14, 2020
The Connecticut Office of Health Strategy and
The Connecticut Office of the State Comptroller

What is Affordable Healthcare?

Healthcare is affordable in Connecticut if a family can reliably secure it to maintain good health and treat illnesses and injuries when they occur without sacrificing the ability to meet all other basic needs including housing, food, transportation, childcare, taxes, and personal expenses or without sinking into debilitating debt.

Measuring Healthcare Affordability in CT

The Office of Health Strategy and the Office of the State Comptroller are collaborating in a two-step project:

Step 1: Update Connecticut's Self-Sufficiency Standard

Step 2: Create a new Healthcare Affordability modeling tool

Working with expert consultants from the University of Washington and UCONN Analytics and Information Management Solutions (AIMS).

With generous support from and in partnership with the Connecticut Health Foundation and the Universal Health Care Foundation of Connecticut.

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Measuring Healthcare Affordability in CT

The Healthcare Affordability Standard is a **modeling tool** that will project the economic impact on households of varying healthcare costs including premiums, deductibles and co-pays.

The modeling tool will calculate affordability based on different wages and family sizes in different regions in our state and will also take into account medical risk level and type of insurance coverage.

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The Self-Sufficiency Standard for Connecticut 2019

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Self-Sufficiency Standard – A Refresher

The federal poverty measure has become out of date and suffers from several problems:

- It is too low,
- It does not vary by place or age of child,
- It does not reflect the realities facing families today.

The Standard is an alternative measure of income adequacy to the official poverty measure that addresses these shortcomings of the FPL.

Self-Sufficiency Standard – A Refresher

The **Self-Sufficiency Standard** is based on a basic needs budget, with amounts for each item set by what the government has determined is adequate for those receiving assistance. There are six basic items:

- Housing
- Child Care
- Food
- Health Care
- Transportation
- Miscellaneous (clothing, toiletries, etc.)
  - We also include Taxes/Tax Credits

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Each Budget Item is Varied by :

Family Composition

Varies by number of adults and age of children, for a total of 719 family types.

Place

Costs vary by where one lives: Manhattan, KA vs. Manhattan, NYC

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Budget Exercise for New Britain

MONTHLY COST	1 ADULT + 1 PRESCHOOLER + 1 SCHOOLAGE
Housing	
Child Care	
Food	
Transportation	
Health Care	
Miscellaneous	
Taxes and Tax Credits	
TOTAL	
Monthly Income	
Annual Wage	
Hourly Wage	

*Assumes the net effect of taxes and tax credits. Tax Credits include the Earned Income Tax Credit, the Child Care Tax Credit, the Child Tax Credit. All tax credits are assumed to be received monthly.

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Budget Exercise for New Britain

MONTHLY COST	1 ADULT + 1 PRESCHOOLER + 1 SCHOOLAGE
Housing	$1,185
Child Care	$1,680
Food	$618
Transportation	$284
Health Care	$506
Miscellaneous	$427
Taxes and Tax Credits	$684
TOTAL	
Monthly Income	$5,384
Annual Wage	**$64,609**
Hourly Wage	$30.59

*Assumes the net effect of taxes and tax credits. Tax Credits include the Child Care Tax Credit, the Child Tax Credit. All tax credits are assumed to be received monthly.

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The Self-Sufficiency Standard for Select Connecticut Places and Family Types, 2019

Town	One Adult	One Adult One Preschooler	One Adult One Preschooler One School-age	Two Adults One Preschooler One School-age
Bridgeport	$24,972	$63,610	$77,566	$81,937
Glastonbury	$26,011	$55,286	$64,609	$72,666
Hartford	$22,398	$51,120	$60,708	$64,833
Middletown	$27,654	$58,156	$68,625	$77,195
New Britain	$26,011	$55,286	$64,609	$72,666
New Haven	$26,111	$55,864	$65,925	$70,391
New London	$25,617	$52,892	$60,918	$69,209
Sprague	$25,588	$52,864	$60,889	$69,152
Stamford	$37,703	$79,020	$94,335	$99,668
Torrington	$25,052	$53,478	$65,082	$73,245
Waterbury	$25,480	$53,565	$64,955	$73,217
Windham	$23,516	$49,179	$56,738	$63,896

An Excel file of all 700+ family types for each town can be downloaded at: https://portal.ct.gov/OHS or www.selfsufficiencystandard.org/connecticut

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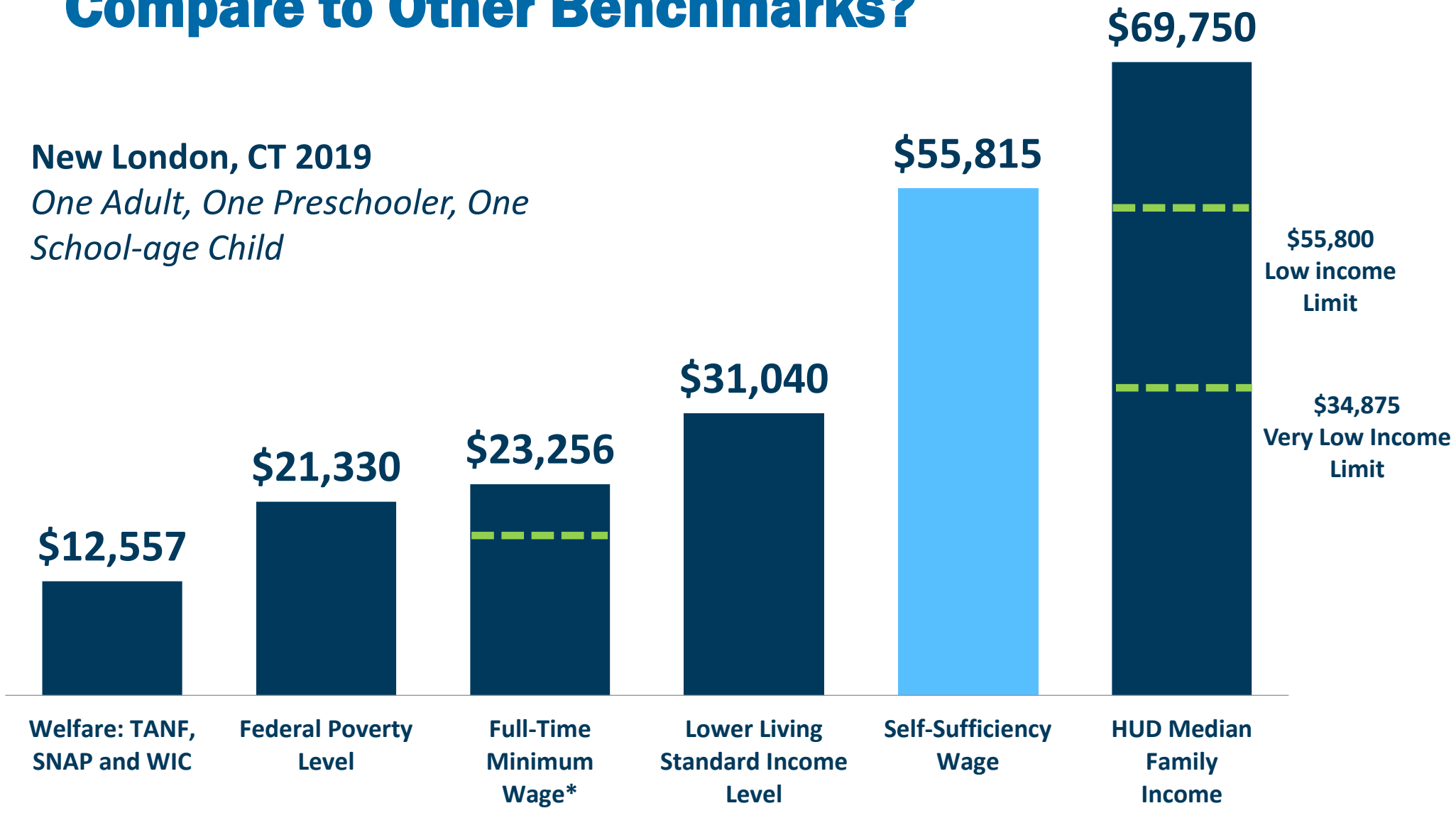
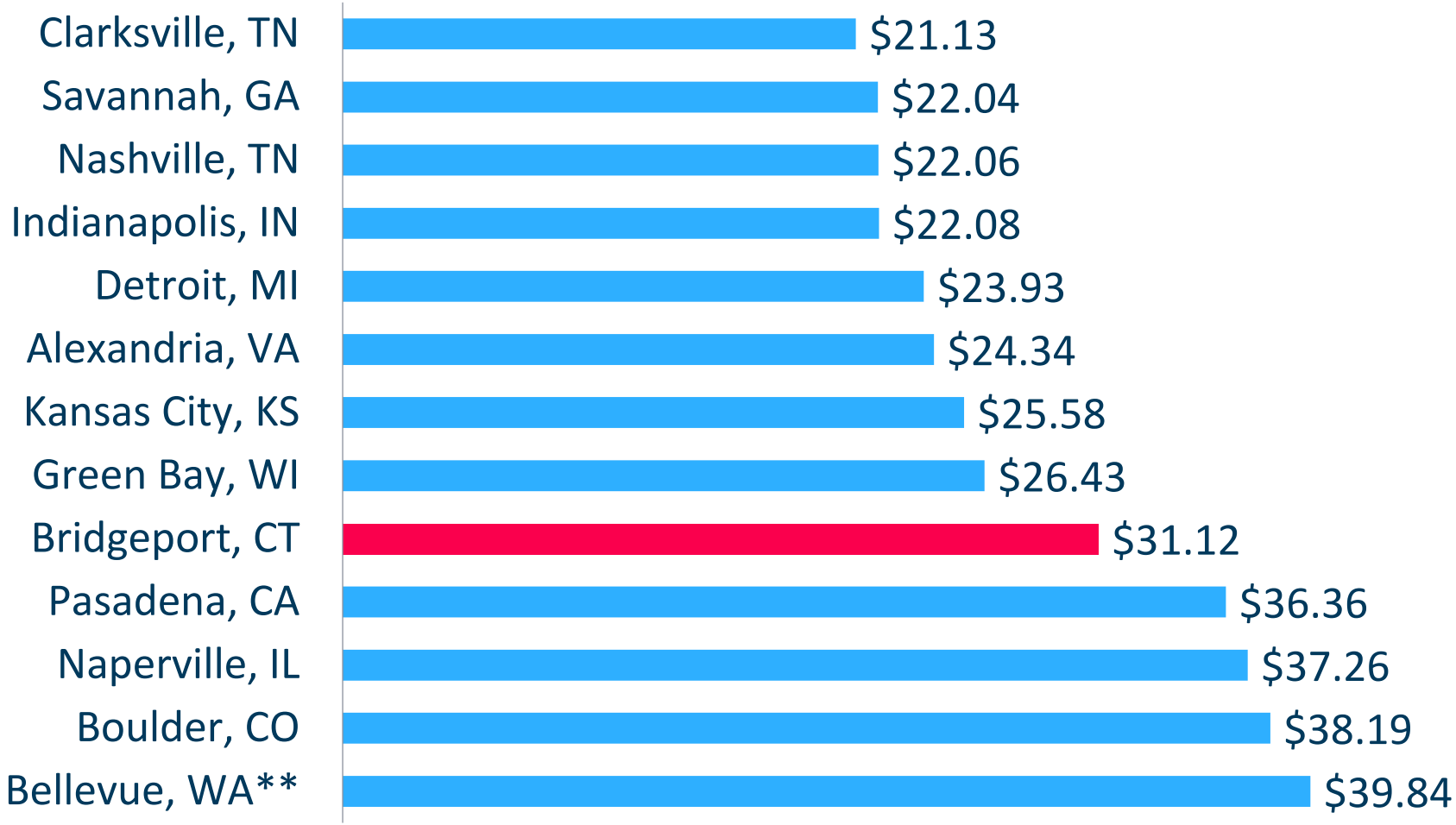
How Does the Self-Sufficiency Standard Compare to Other Benchmarks?



How Do Costs in Connecticut Compare?

Bridgeport Compared to Other U.S. Cities, 2019

One Adult, One Preschooler, One School-age Child



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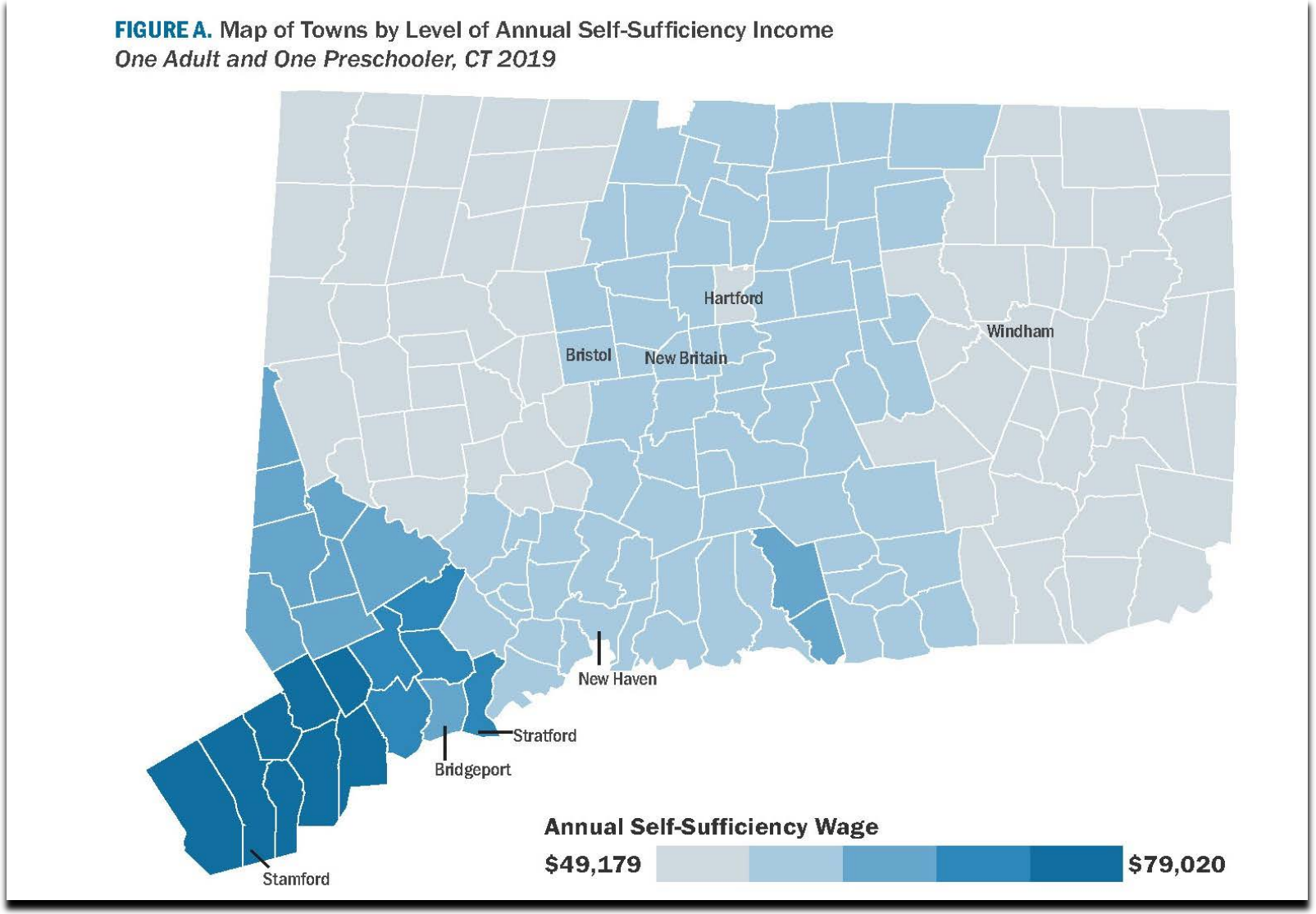
How Does The SSS Vary Across Connecticut?

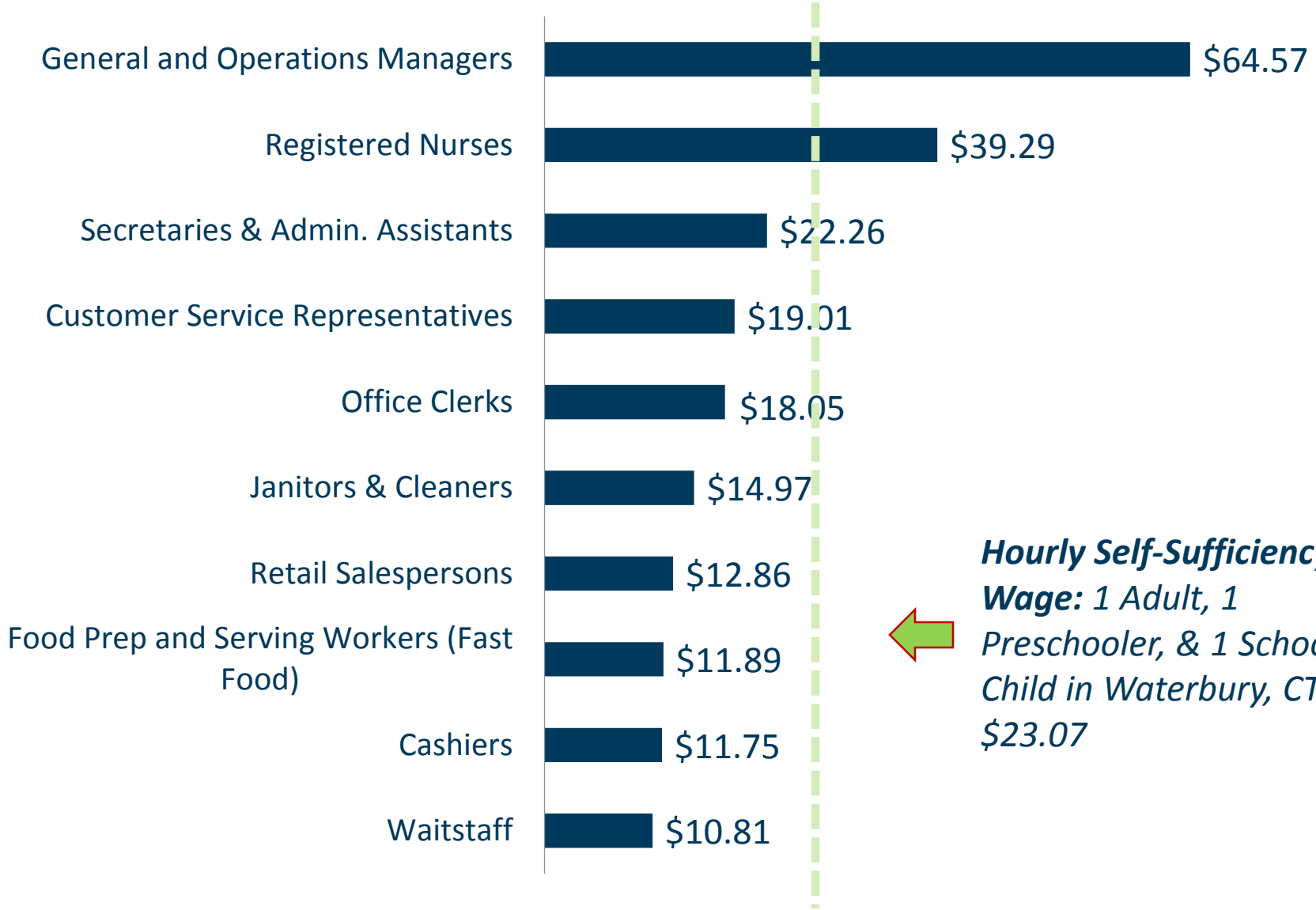
The Self-Sufficiency Standard For One Adult And One Preschooler, 2019



Who Lacks Adequate Income By Race/ Ethnicity?

How Do Connecticut's Top 10 Jobs Compare?

The Standard Compared to Median Wages of Connecticut's Ten Largest Occupations



Hourly Self-Sufficiency Wage: *1 Adult, 1 Preschooler, & 1 School-age Child in Waterbury, CT $23.07*

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The Impact of Work Supports

Hartford, CT 2019: One Adult, One Preschooler, One School-age Child

Wage Needed Without Work Supports =
$5,097 per month

MONTHLY EXPENSES	
TAXES	$ 1,045
MISC	$ 405
HEALTHCARE	$ 506
TRANSPORTATION	$ 63
FOOD	$ 618
CHILD CARE	$ 1,680
HOUSING	$ 1,185
TAX CREDITS	$ 405

Wage Needed With Work Supports =
$2,472 per month

EXPENSES AFTER WORK SUPPORTS	
TAXES	$ 337
MISC	$ 405
HEALTHCARE	0
TRANSPORTATION	$ 63
FOOD	$ 371
CHILD CARE	$ 660
HOUSING	$ 730
TAX CREDITS	$ 94

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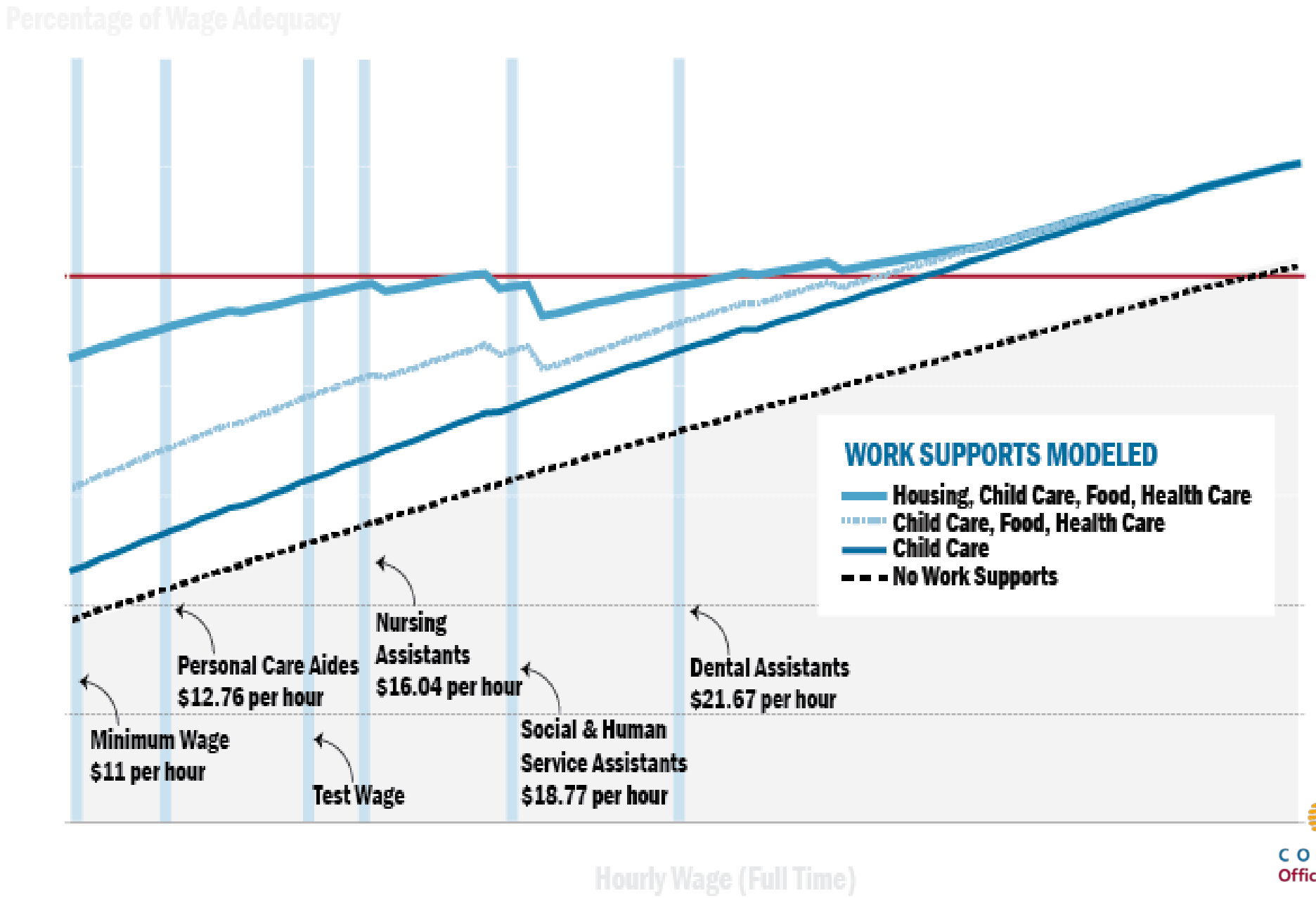
How Work Supports Impact Wage Adequacy



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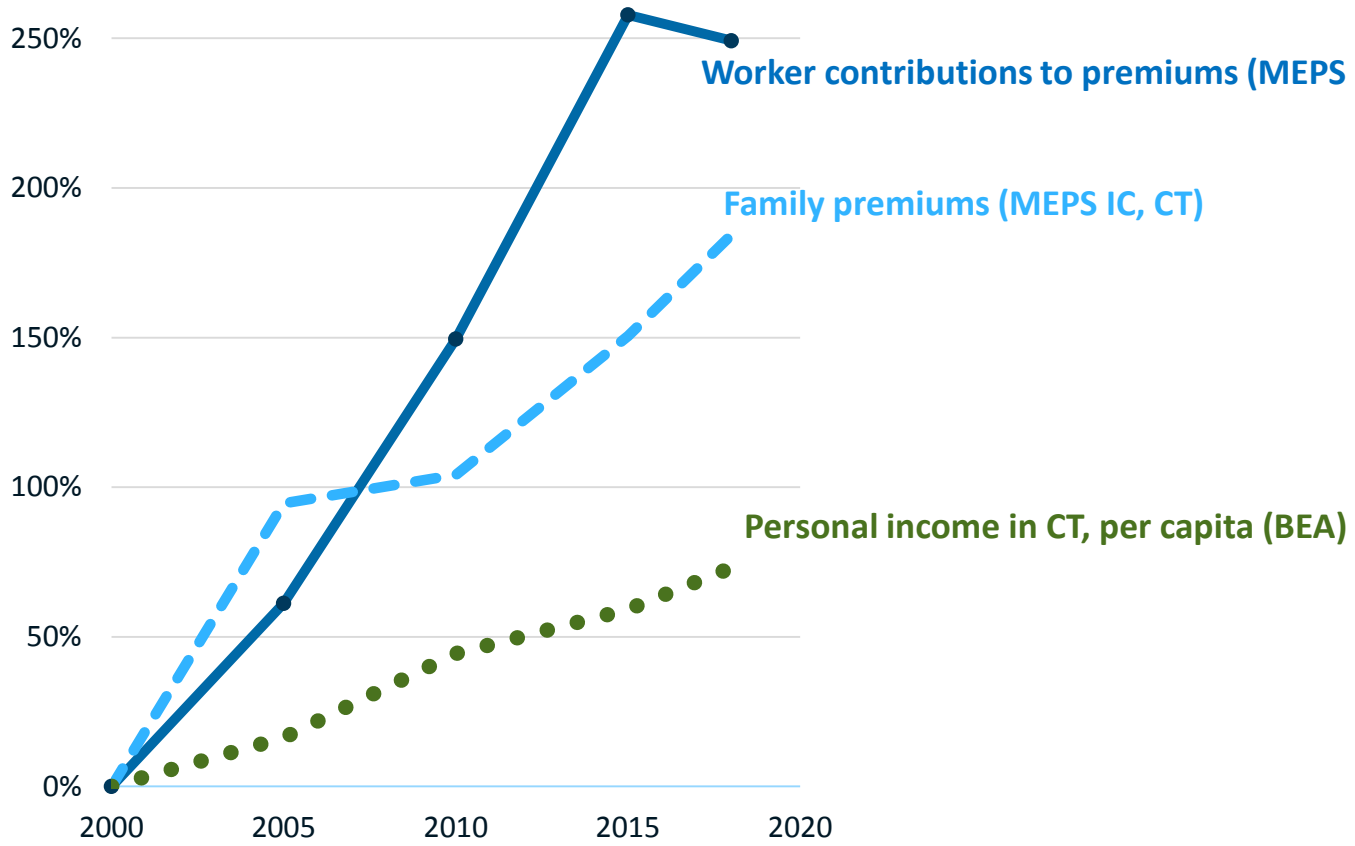
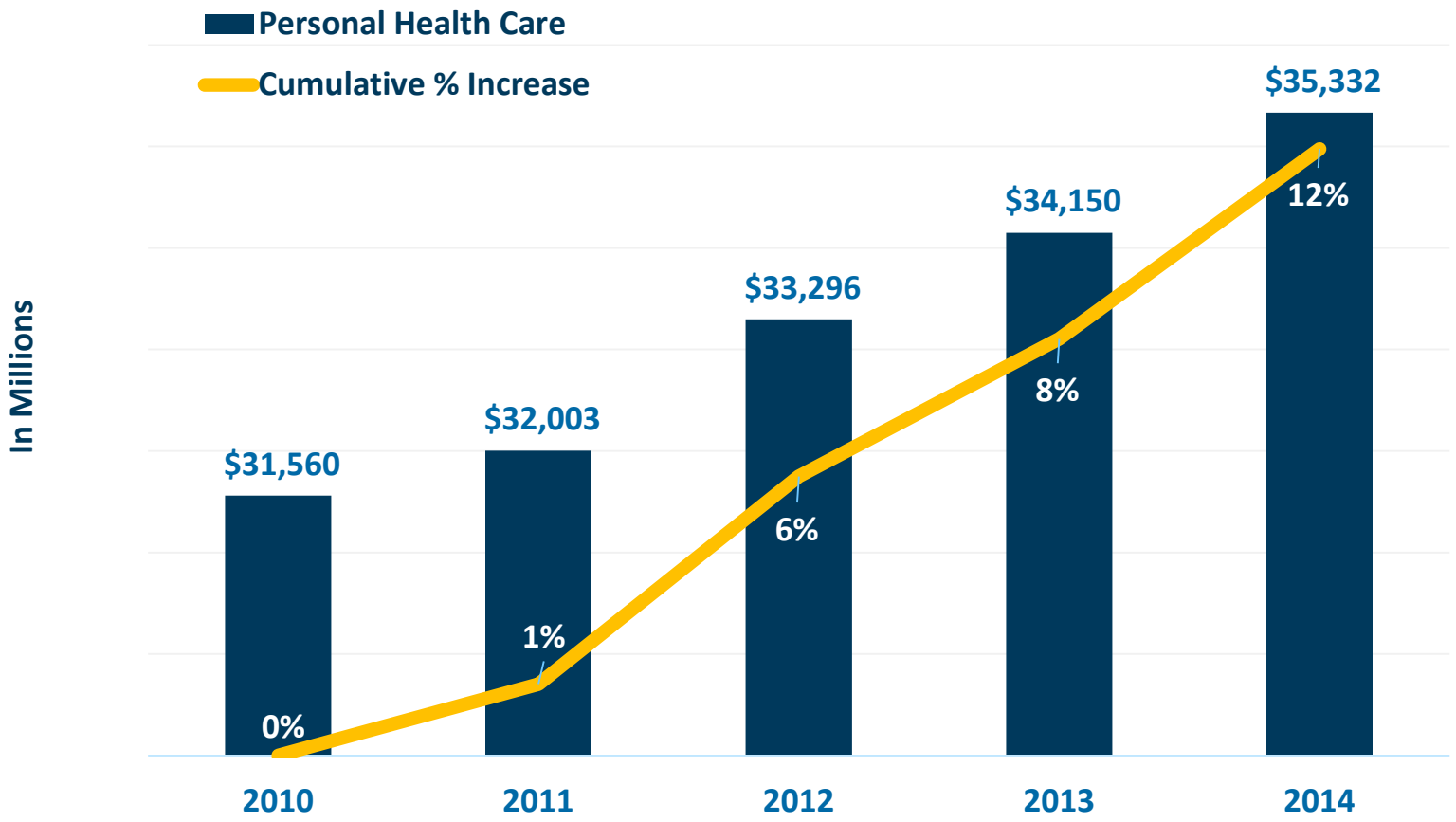
Healthcare remains unaffordable to many

Since 2000, Connecticut employer-sponsored insurance premiums have grown **two and half times** faster than personal income



Source: Medical Expenditure Survey, Tables D.1 and D.2 for various years

Personal Health Care Expenditures in Connecticut grew 12% in five years



Personal Health Care Expenditure as a Percentage of GDP averaged 14% from 2010-2014

Source: CMS State Expenditure by Provider 2014

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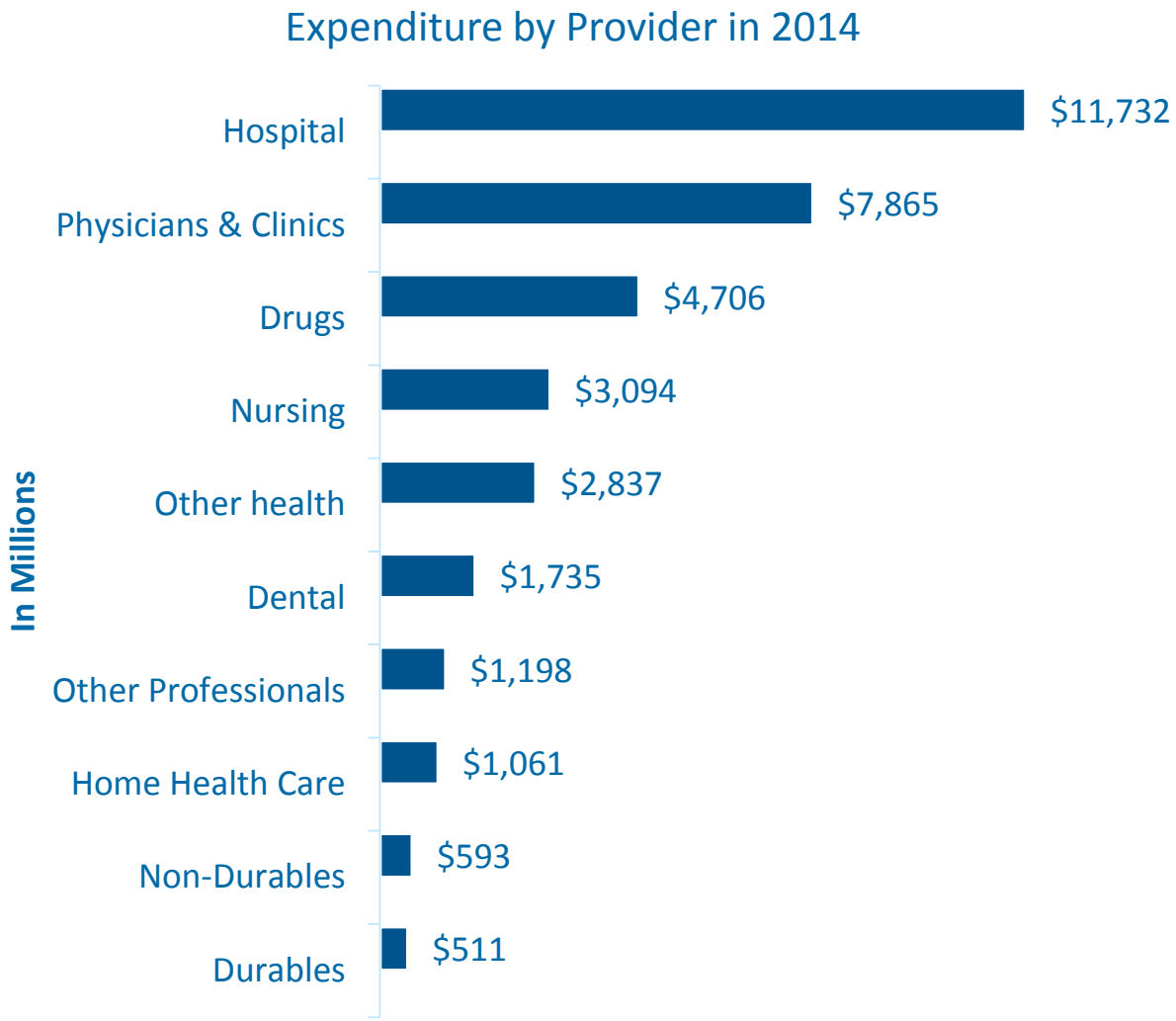
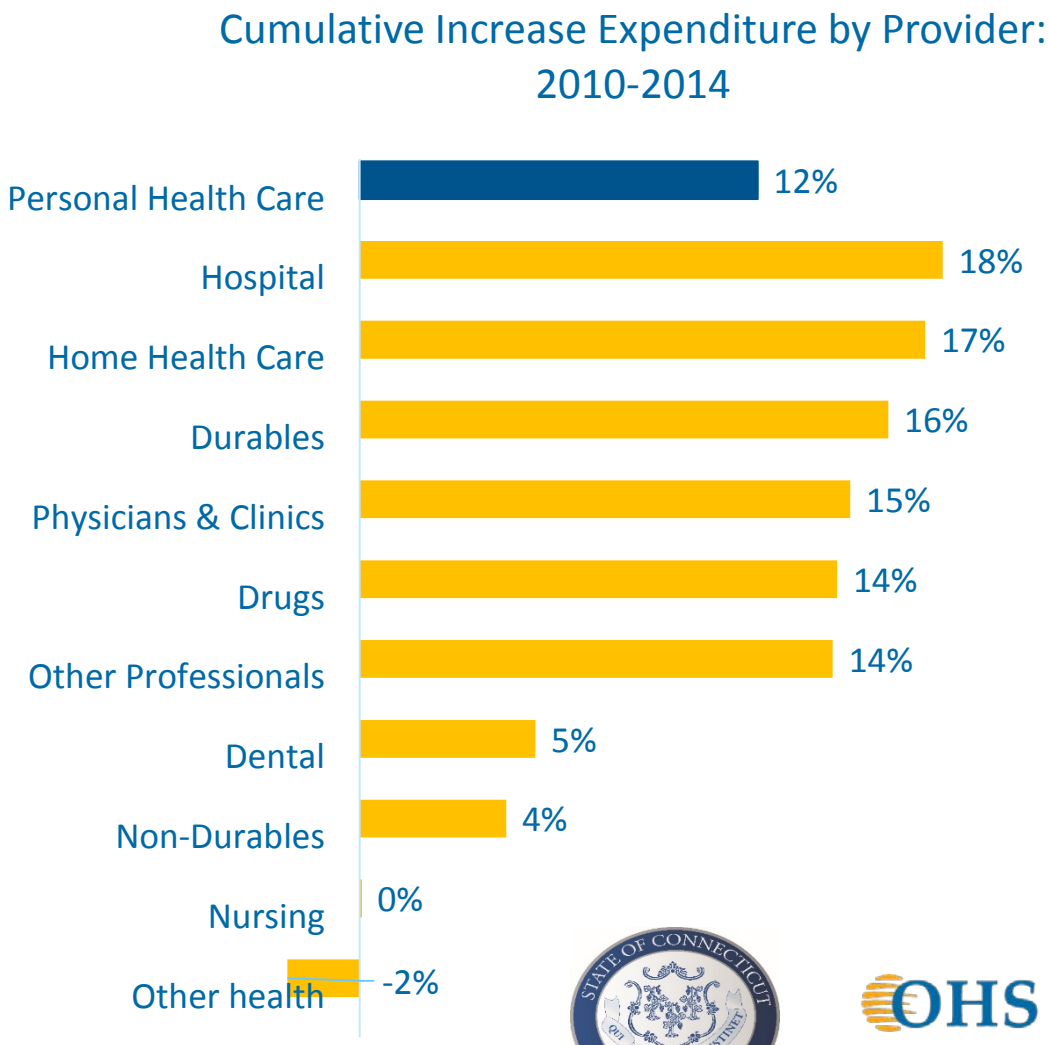
Top Three Expenditure Areas in CT …
Hospital, Physicians & Clinics and Prescription Drugs





Source: CMS State Expenditure by Provider 2014

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Healthcare Affordability Modeling Tool

In order to assess the affordability of different health care policies, the University of Washington team will substitute the current health care costs in the Self-Sufficiency Standard budget with more detailed health care cost projections provided by the UCONN team.

Health care projections will vary by:

- Insurance status
- Health risk status
- Demographic characteristics

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Healthcare Affordability Modeling Tool

Using the 2019 Self-Sufficiency Standard as a framework, the CT Healthcare Affordability modeling tool will help decision-makers and stakeholders assess how different health care policies will affect the ability of Connecticut residents to meet their healthcare costs without sacrificing other basic needs including housing, food, transportation, child care and taxes, or without falling into debilitating debt.

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Appendix K

HUSCH BLACKWELL

MEMORANDUM

Date: January 10, 2020

To: Layne S. Gakos, General Counsel, Connecticut State Medical Society

From: Husch Blackwell LLP

Re: Analysis of HSA Distributions and Qualified Medical Expenses

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BACKGROUND

This memorandum is in response to your question concerning the possibility of legislation shifting the burden of collecting fees attributable to provider services rendered on behalf of individuals enrolled in a high deductible health plan ("HDHP"). Specifically, you asked whether shifting the burden of collection from a service provider to a HDHP carrier would disqualify an enrollee's Health Savings Account ("HSA") under Section 223 of the Internal Revenue Code (the "Code") or result in an impermissible HSA disbursement.

You also asked whether shifting the burden of collection to the insurer would prohibit an enrollee from using his or her HSA funds to pay the provider fee because the payment could be viewed as a "debt" rather than a qualified medical expense.

We understand that there is a movement nationally among the American Medical Association and some state medical associations to obligate insurers to collect deductibles for HDHP enrollees directly from enrollees. The intent in part is to reduce the collection burden placed healthcare providers.

SHORT ANSWER

Based on existing tax law and IRS guidance, we conclude that the collection of pre-deductible medical expenses by an insurance carrier from an enrollee in a HDHP should not have any impact on the enrollee's HSA. Further, distributions from the HSA to the insurer for pre-deductible medical expenses should constitute qualified medical expenses.

DISCUSSION

Qualified Medical Expenses

Amounts contributed to an HSA are generally tax deductible up front[1] and disbursements from the HSA are excluded from taxable income so long as the disbursements are made to pay or reimburse the HSA owner (or the HSA owner's spouse or dependents) for qualified medical expenses.[2] Amounts distributed

[1] Code §223(a).

[2] Code §223(d)(1).

from the HSA that are not used to pay or reimburse qualified medical expenses are included in the HSA owner's taxable income for Federal tax purposes and are subject to a 20% excise tax.[3]

A "qualified medical expense" means an amount paid for medical care, as defined by Section 213(d) of the Code relating to itemized deductions for medical expenses.[4] Nothing in the Code, Treasury regulations or other IRS guidance impose any restriction on the nature of the payee as it relates to the status of a qualified medical expense. We are also unaware of any case law on point. Thus, there is no requirement that HSA funds be paid directly to a provider of the services as opposed to the insurer of the HDHP in order for distribution to be considered a qualified medical expense. This conclusion is consistent with Section 213(d) which refers to "amounts paid for" medical care and ***not*** "amounts paid to" a provider for medical care.

Regarding the potential characterization of the HSA disbursement as a "debt," we are not aware of any authority supporting such interpretation. So long as the distribution from the HSA is to pay or reimburse an amount that originated as an expense for medical care within the meaning of Section 213(d) of the Code and the enrollee has the records to substantiate the expense, the distribution should be viewed as a permissible HSA distribution. In support of this position, we note that there is no dispute that a HDHP enrollee may pay a provider with a credit card and then later use HSA funds to pay the credit card bill. Payment of the credit card bill (i.e., debt) does not cause the HSA distribution to be re-characterized as an impermissible distribution.

We also note that an HSA is a personal account. Enrollment in a HDHP is independent of an individual's decision to enroll in, make contributions to, or take distributions from an HSA. That is, someone may choose to enroll for HDHP coverage without maintaining or contributing to an HSA. Current tax law and IRS guidance would not permit an arrangement by an insurer to mandate an HDHP enrollee to contribute to an HSA or to use HSA funds to pay pre-deductible medical expenses.

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This memorandum is rendered solely for the benefit of the firm's client the Connecticut State Medical Society ("CSMS"). This memorandum may not be relied upon by anyone other than CSMS as legal advice. The conclusions, statements, and views expressed in this memorandum are based upon statutory, regulatory, and judicial authority existing on the date hereof, any of which may be changed at any time. The scope of this memorandum is limited to those subject matters expressly addressed herein; any other subject matter not discussed herein, is outside the scope of the issues evaluated and the conclusions reached herein.

[3] Code §223(f).

[4] Code §223(d)(2).

GROOM LAW GROUP

MEMORANDUM

February 4, 2020

TO: Susan Halpin, Connecticut Association of Health Plans

FROM: Groom Law Group

RE: Potential Recommendation Requiring Carriers to Collect Member Cost-Share

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On June 26, 2019, Governor Lamont signed Public Act 19-117. Section 247 of the Act created a High Deductible Health Plan Task Force ("Task Force") "to study the structure of high deductible health plans and the impact of such plans on enrollees in this state." This memorandum addresses the issues regarding a suggested Task Force recommendation that would support legislation requiring carriers, rather than providers, to collect members' deductible amounts. As discussed below, any such potential legislation would raise significant issues with the HSA-compatible status of a high deductible health plan ("HDHP"). For example: (1) a carrier's payment of the deductible could be viewed as the HDHP paying an amount prior to the satisfaction of the deductible; and relatedly, (2) when the carrier credits the deductible with amounts it knows the member did not actually pay, the HDHP may no longer be HSA-compatible.[1]

Although this memorandum is limited to these two issues, there are a host of other issues that should be considered prior to further consideration of the proposal. For example whether: (1) this approach could render certain HSA expenses as no longer qualifying medical expenses under the Code (e.g., to the extent the expenses constitute consumer debt); (2) the additional administrative costs associated with the carrier trying to collect from the patient the deductible amount paid by the carrier would pose compliance issues under state and federal medical loss rebate rules; and (3) the decision by the carrier to forgive the deducible amount owed raises issues under state anti-rebating laws. Please note that these are just a few of the many issues that should be considered. We also note that we do not believe there is a movement afoot by the states to adopt similar legislation.

Legal Framework

To be eligible to contribute to an HSA for a month, an individual generally must have HDHP coverage as of the first day of the month and must not be covered by any other "health plan" that (1) is not an HDHP and (2) provides coverage for any benefit that is covered under the HDHP. Code § 223(c)(1)(A). Certain types of coverage, called permitted insurance (e.g., insurance for a

[1] This is beyond the scope of this memorandum, but we note that this state legislation may also raise federal preemption concerns.

specified disease or illness) and permitted coverage (e.g., dental/vision coverage), are disregarded. Code §§ 223(c)(1)(B) and (c)(3).

An HDHP generally means a health plan that (1) has an annual deductible of at least $1,400 for self-only and $2,800 for family coverage (for 2020) before any reimbursement is made for eligible medical expenses (other than preventive care) and (2) has a maximum out-of-pocket amount of $6,900 for self-only and $13,800 for family coverage (for 2020). Code § 223(c)(2)(A).

In Notice 2008-59, Q&A-3 (June 25, 2008), the IRS stated that an employee is not eligible to contribute to an HSA if at any time his/her employer pays or reimburses, directly or indirectly, all or part of employees' medical expenses below the minimum HDHP deductible (other than permitted coverage or preventive care). The IRS also has held that in order for an individual to be an HSA-eligible individual, a prescription drug plan that is part of an HDHP must subject all covered expenses, including for prescription drugs, to the minimum annual deductible. Rev. Rul. 2004-38 (April 12, 2004).

The IRS has, however, also concluded that an employer's purchase of a pharmacy discount card will not cause an individual to become ineligible to contribute to an HSA, as long as the individual is responsible for paying the costs of the drugs (after the discount) until the deductible is met. Notice 2004-50, Q&A-9 (July 23, 2004). Although the discount itself would not cause the individual to be ineligible to contribute to an HSA, the IRS said that the HDHP must disregard drug discounts and other manufacturers' and providers' discounts in determining if the minimum deductible for an HDHP has been satisfied, and only the amounts actually paid by the individual can be taken into account. *Frequently Asked Questions (FAQs) about Affordable Care Act (ACA) Implementation Part 40* (August 26, 2019).

Potential Issues

We understand that certain stakeholders have voiced concerns that the potential recommendation could cause adverse, unintended consequences for consumers. Below, we address two specific issues related to HSAs and related HDHPs. The first issue arises to the extent an HDHP enrollee has not yet satisfied the minimum statutory deductible under Code § 213, and the carrier's payment of the deductible is viewed for purposes of federal tax law as the plan paying an amount *prior to* the HDHP enrollee's satisfaction of such deductible. The second issue arises where the enrollee fails to pay the carrier the full amount of the deductible otherwise paid by the carrier to the provider. We address each of these, in turn, below.

1. Carrier's Payment of the Deductible

There is a risk that the IRS would view the carrier's payment to the provider of the deductible amount as the HDHP paying the individual's medical expenses before the individual satisfied the deductible, similar to examples in IRS guidance where the employer paid an employee's medical expenses before the minimum HDHP deductible and/or where the prescription drug plan paid benefits pre-deductible. This risk may be lessened if the member repays the carrier in full

because then arguably the plan did not pay any medical expense pre-deductible and the member satisfied the deductible.

Where, however, the member does not repay the carrier in full the plan appears to have paid a medical expense pre-deductible. While counterarguments may be made[2], as explained in the *Potential Consequences* section below, this may create real jeopardy for the HSA owner.

2. Deductible Credit

An even bigger risk exists when the member does not repay the carrier in full and then the carrier credits the member's deductible for the provider's full charge. In that case, the carrier would be crediting the deductible with an amount it knows the member did not actually pay. This seems directly akin to the situation in the FAQ where the member receives a pharmacy discount or rebate and the carrier credits the deductible with the discounted/rebated amount, which the IRS has specifically said would render the HDHP no longer HSA compatible.[3]
We think it is important to distinguish this situation from the typical situation where the member sees a provider before he/she has satisfied the deductible, the provider submits a claim to the carrier, and the carrier credits the member's deductible with the member's cost-share amount. The typical situation does not raise HSA issues because, to the best of the carrier's knowledge, the member pays the provider the full amount owed. Although in some situations, the member may not end up paying the provider the full amount owed, either because the member does not pay the provider at all or because the provider sends the unpaid bill to a collection agency that accepts a reduced payment from the member, the carrier has no actual knowledge that the member did not pay the provider. Under the possible recommendation,, however, the carrier has actual knowledge that the member did not actually pay the full amount.

Potential Consequences

The potential consequences of the HDHP failing to be HSA-compatible have the most impact on the consumer. This is because the individual would not be considered an "eligible individual" who was able to contribute to an HSA. Thus, the individual's HSA contributions for the time period that he/she is covered under the HDHP would be subject to a 6% excise tax until they are withdrawn. Code § 4973(g). If the plan is a group health plan, there could also be adverse tax consequences to the employer if the employer or employees made pre-tax contributions to the HSAs.

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[2] In that case, it may be possible to argue that the arrangement is similar to the pharmacy discount card scenario and that the carrier's payment represents a discount on the provider's services. Unlike the pharmacy discount card, however, where the discount is provided by an unrelated third party, here, the plan itself is paying the "discount."

[3] We considered whether this risk could be reduced if in practice the carrier instead does not credit the deductible with any amounts until the member repays the carrier, and then only credits the actual repayment amount. However, this could result in administrative difficulties for accumulating amounts towards the deductible accumulators that the member incurs before he/she repays the plan and/or this could cause the member to exceed the maximum out-of-pocket limit (which could raise both HSA and Affordable Care Act concerns).

* * * * *

We hope that this is helpful. Please let us know if you have any questions or would like to discuss.