

HealthFirst Connecticut Authority

Co-Chairs
Margaret Flinter
Tom Swan



Cost, Cost Containment and Finance Workgroup

Meeting Summary

April 11th, 2008

9:00 AM, Room 1E of the LOB

The following members were present: Tom Swan, Margaret Flinter, Al Ayers, Evelyn Barnum, Leo Canty, Tanya Court, John Farrell, Paul Filson, Stephen Frayne, Andrew Gould, Adele Gordon, Paul Grady, Mickey Herbert, Sanford Herman, Yvette Highsmith-Francis, Michael Hudson, Karl Ideman, Sharon Langer, Paul Lombardo, Sal Luciano, Joseph Pavano, Connie Razza, Bob Rinker, Alyssa Rose, Jamie Stirling, Robert Tessier, Victoria Veltri, and Jill Zorn.

Also present were: Eric George representing John Rathgeber

Tom Swan welcomed members to the meeting. He explained Randy Bovbjerg and Barbara Ormond's roles as facilitators of the HealthFirst Connecticut Authority and State-Wide Primary Care Access Authority. Their services have been secured by Academy Health. At the previous HealthFirst Authority Meeting, John Holahan presented state-based reform efforts in other states with a focus on Massachusetts, Colorado and New York. Kristen Anderson, Jennifer Jaff, Victor Vallagro, and Richard Antonelli, all offered presentations to the Quality Access and Safety Workgroup was. At the next HealthFirst Authority meeting, Randy Bovbjerg and Barbara Ormond will lay out four models of reform and the issues surrounding those models: 1.) An all-payor or single-payer system, 2.) A model that builds off of the existing employer based system. 3.) A pooling concept. 4.) A state-wide primary care plan.

Tanya Court suggested that a fifth option, "no change in the healthcare system," be examined for the purpose of setting benchmarks for the other scenarios.

Tom Swan introduced Michael Miller of Community Catalysts.

Michael Miller introduced himself as a generalist in health policy. He suggested that the term "cost containment," is not a useful framework to use to address the problems in our healthcare system. It is hard to determine what is the "right," amount of money to spend on healthcare. When the United States is put into an international context, it appears that the U.S. spends more money on healthcare and receives worse outcomes and lower satisfaction. There are several reasons for this:

- 1.) The U.S. seems to spend more because purchasing is much weaker and less coordinated than it is in the rest of the industrialized world.

- 2.) On average, more of our healthcare dollar is spent on high-tech and specialty care without corresponding improvement in outcomes.
- 3.) We have higher administrative costs and a very unequal distribution of healthcare resources.

There will be a public perception challenge facing healthcare reform. Typically, people associate more care and higher priced care with better care. The connection between higher priced care and better care is a fallacy.

The second problem is the vested interest in the status quo. This makes it hard for political change to occur.

The third issue that will need to be addressed is the issue of coverage.

The perception that the reason there are high healthcare costs due to “over-coverage,” is not justified when you look at other countries where there is better coverage and lower costs.

The proponents of “cost-sharing,” have recently conceded that the potential gains of cost sharing have been overstated.

Michael Miller offered several healthcare plans to the Workgroup that other states have experimented with. The first is “pay for performance,” which is a system that rewards progress towards specified goals. We need to change the way we incentivize healthcare. For example, hospitals should be encouraged to keep people out of the hospital. The incentives must be transparent to payors, providers and the public. The system by which incentives are offered should be simple so that people can make sense of them.

Regulation in healthcare is the second possibility. There is a lot of market failure and consolidation and little traditional competitive dynamics. The effort in Maine includes a limited state-wide capital budget and a health plan that is judged ad hoc. Maine has seen an increase in the number of proposals that are being withdrawn or reconsidered which may mean there is some reason to be encouraged that their plan may be successful. Insurers in the state were given two choices: You could maintain a higher loss ratio and be exempt from the rate review process. If you agreed to that higher loss ratio and did not meet your minimum threshold, you were committed to rebating the excess to your customer base. If you did not want to maintain that higher medical loss ratio, then you could be subject to rate review.

A third concept is improving care coordination for the chronically ill and for high cost cases. Some experiments in this area have been effective. Commonwealth Care in Massachusetts is looking at the key elements of success which includes electronic medical records (EMR), development of a cooperative care plan, case management, patient education and self management. Essential to this plan is the coordination or integration of financing streams.

Administrative efficiency ought to be improved. In America we have one of the most complex administrative systems in healthcare. There are incredibly heavy costs imposed by unlimited variation and unlimited choice. There may be too many choices for consumers making it impossible for them to make sense of the differences between plans.

In the public sector, coordinated public sector purchasing has been examined. Medicaid, state-employees, other health and service agencies, the prison system, and if you include municipalities, the public sector is a huge purchaser.

The country is in a primary care crisis. Many states are looking at strategies to increase the number of primary care providers, and to be able to provide medical homes for the population.

Another area where we can improve the value for our healthcare dollar is medical technology review. This is best done at the Federal level because it is duplicative for different states to make the reform in parallel. Until that change occurs, states can look at research done in other countries and build on that success. States could also look into cross-state compacts where states could share some of the costs.

Smarter prescription drug purchasing could include generic drug substitution, formulary design, therapeutic substitution, reliance on neutral experts instead of the drug industry with regard to cost-effective prescribing, and finally, the federal government should review the policy of allowing drug companies to advertise.

Finally, it is obvious that the underlying burden of illness is closely correlated to what we spend on healthcare. Financially, the easiest scenario for the healthcare system is a healthy individual who has a relatively short illness at the end of life and therefore is less expensive to the healthcare system. Investing in a healthier population is cost effective. Tobacco control, HIV prevention, and other healthy initiatives could help decrease the cost to the healthcare system.

Jill Zorn asked if the insurance market would be hard to regulate due to the high percentage of self-insured plans.

Michael Miller responded that having more plans actually dilutes the market power. Having a limited number of plans could produce a better outcome than a few unregulated plans or a lot of plans that compete on risk selection or avoidance.

Eric George asked for explanation on the concept of regulation. There are already regulations on the small group market.

Michael Miller explained that regulations would apply to the issues of underwriting, guaranteed issue, premium variation, but not around rate increases.

Eric George explained that in the rating system in the small group market there are a lot of overlays. This system could be described as an adjusted community rating system, which sets a community rate and an insurance company can use a limited number of factors to deviate from that rate.

Jamie Stirling asked about the issues that might affect end of life spending and what might make it possible to avoid unnecessary end of life spending.

Michael Miller responded that there is often resistance to raising the issue because it is a controversial issue. We do not deal well with death in our society. One potential solution to this problem is the

creation of a system in which people could make their final wishes known. This system may also need to include a protection for physicians and providers for following those directives, and incentives or sanctions for not following those wishes. These changes could help save the healthcare system money with respect to end of life care. Many people would not want to be kept alive while in pain indefinitely at the end of their lives.

Sanford Herman asked what kind of incentives could be used to increase the number of primary care providers and internists.

Michael Miller explained to the Workgroup that in Massachusetts there is currently legislation that would expand the scope of practice for nurse practitioners, expanding the number of physician assistants that physicians can supervise, increasing the number of available primary care positions at universities, increasing loan forgiveness, sanctions on those who avoid their commitments, and improving cognitive work that primary care practitioners perform.

Mickey Herbert agreed that medical technology review must be done at a federal level, value based benefit design, and greater public health initiatives with respect to healthy lifestyles but cost must remain an issue. Mickey Herbert noted that he did not have many encouraging words with regard to containing cost in the healthcare system.

Michael Miller responded that pay for performance can work and has seen mixed results in other states. Healthcare is not an ordinary consumer good, and it has been very difficult to control healthcare costs. Michael Miller disagreed that there is a particular level of health spending that the United States of America can afford or cannot afford and that that level has been reached.

Bob Madore suggested that cost and cost containment is part of breaking through the status quo.

Paul Lombardo asked how you could get to a point where experts and consumers can act in such a way that they are not biased by their own financial incentives to reach a healthcare system that is more functional and cost effective for everyone.

Michael Miller explained that finding financially neutral experts is close to impossible. As long as the experts are not directly paid by the pharmaceutical industry as a condition of their involvement in reaching a better healthcare system.

Andrew Gold reported a lack of a role for consumers and any accountability for the consumers. The consumer should have an obligation to help improve their own health. They need to know that they share responsibility for their role in the healthcare system.

Michael Miller responded that the United States has more consumer price accountability than any other country, yet we are spending far more on healthcare. There must be a role for patient responsibility but part of the problem is that a large amount of money is spent on a small number of very sick people. To avoid this problem we must give patients the support and the care they need to manage their own care. Some states are experimenting with the idea of sanctioning people who do not meet certain health targets by taking away certain benefits. This is a self-defeating policy because by sanctioning people who have not met their health needs, you are taking away the care for the people who need it the most.

Sal Luciano agreed that pooling does not work. He addressed the issue of private coverage. Sal Luciano described a situation in which a private company stops offering health care plans. He made it clear in his scenario that when a situation like that occurs, taxpayers still need to pay for that person's healthcare. Finally, there is a distinction between prolonging life and prolonging death. If a person is terminally ill, we must consider that situation.

Paul Grady explained to the Workgroup that personal healthcare spending between 1994 to 2004 increased from 12 billion to 22 billion dollars. That increase is due to personal healthcare spending not plan design or insurance.

We need to address the capability of our system to deal with chronic illnesses. Paul Grady asked Michael Miller how aligned our healthcare system is with regard to caring for chronic illness.

Michael Miller responded that our healthcare is not aligned at the payor level. There is a disconnect between Medicare and Medicaid. Incentives are not aligned at the payor level. There are also significant problems in care organizations. People with multiple chronic illnesses do not have a healthcare structure that supports them.

Michael Miller explained that not all of our healthcare spending is producing measurable benefit. Many people are invested in the status quo and it is necessary to find political will to make the changes to benefit the healthcare system. Unfortunately, sometimes it takes a crisis before that change occurs.

Stephen Frayne asked for an explanation that cost shifting has on the cost curve. The average rate of growth in hospital expenditures in the last five years has been 5% per year. Those in the payor community will tell you that has not been their experience. They have seen larger growth. There must be a greater participation from Medicare and Medicaid. He asked how we could provide more affordable coverage to those who have coverage, and how do we get coverage to those who do not have it.

Tom Swan explained that the purpose of the Workgroups was not limited to discovering a way to find insurance for the uninsured but also to look at the development of a healthcare system that is sustainable.

Karl Ideman suggested there is a large concentration of risk and cost in our healthcare system.

Tom Swan noted that value based healthcare seemed to continue to find agreement in the Workgroup.

John Farrell informed the Workgroup that in the last few years the cost of technology has become very affordable and very powerful. The software technologies related to the issue of healthcare claims has become more sophisticated.

Tom Swan Announced the date of the next meeting, May 9th, 2008.