

# HealthFirst Connecticut Authority

Co-Chairs  
Margaret Flinter  
Tom Swan



Legislative Office Building  
Room 3000  
Hartford, CT 06106

Phone  
(860) 240-5255

Fax  
(860) 240-5306

E-Mail  
[healthfirstauthority@cga.ct.gov](mailto:healthfirstauthority@cga.ct.gov)

## **Cost, Cost Containment and Finance Workgroup September 25<sup>th</sup>, 2008 Room 1E of the LOB Meeting Summary**

Members Present Were: Tom Swan, Karl Ideman, Paul Lombardo, Mickey Herbert, Bob Rinker, Jill Zorn, Jamie Stirling, John Farrell, Andy Gold, Henry Jacobs, John O'Connel, Victoria Veltri, Sharon Langer, Ludwig Spinelli, Evelyn Barnum, Paul Grady, Tanya Court.

Also Present Were:

Tom Swan called for a motion to approve the July 29<sup>th</sup> Meeting Minutes.

A motion to approve the minutes was made and seconded.

The meeting minutes were approved.

Tom Swan reported that a contract is almost finalized with the University of Connecticut Health Center. That report will build off of the report that the state medical society had recently completed.

Henry Jacobs announced that CSMS had announced that data at a meeting recently. Some of the data included in the report is valid but the study is a report of approximately 1000 respondents and therefore there is no way to know how accurate the data is.

Tanya Court reported that the findings in the report are consistent with the knowledge that physicians avoiding primary care because of the lack of pay in the field. Approximately 25% of doctors in Connecticut are over 60 years old and that should cause concern because it takes a long time to train new doctors.

Tom Swan reported that four community forums had been held so far out of the ten total forums. The participation has ranged from 70 to 30 in Putnam.

Jill Zorn reported that the public hearing in Putnam was interested and there was a wide variety of testimony.

Tom Swan discussed the working outline that the Authority will use as a framework as the HealthFirst Authority approaches a final report.

I) Creation of Quasi Public Trust charged with:

Administration of coverage programs in which state of Ct. has an investment in managing value

- a. data collection and analysis
- b. Monitor risk segmentation and address adverse selection, as needed
- c. Health Planning
- d. Establishing standards
- e. Establishing timing for phase in of coverage and system changes
- f. Portfolio to include state employee plans, charter oak, newly created coverage options; option to include Husky/SAGA/Medicaid/Medicaid PCCM in future
- g. Serve as liaison with plans outside of this portfolio
- h. Monitor directly or indirectly progress towards reduction of racial and ethnic health disparities
- i. Appointments to Trust to represent broad stakeholders group

II) Quality improvement and cost containment

- a. Improving quality through transformation of delivery system (\* indicates potentially cost-saving initiatives)
  - i. Achieving “medical home” status: process and rewards\*
  - ii. Chronic disease management, care coordination, care management, and case management: subset of the Trust, community based if unable to do at the practice level\*
  - iii. Health Promotion and prevention, with incentives for individual responsibility\*
  - iv. Value based plan design that incorporates evidence based medicine\*
  - v. Integration of primary care with oral and behavioral health\*
  - vi. Patient safety standards\*
  - vii. Data collection and transparency
  - viii. Electronic Medical records: accelerating adoption, incentives and support\*
  - ix. Achieving 100% e-prescribing across Ct.\*
    - x. Auto-enrollment in Medicaid at point of licensure for providers
    - xi. Increase Medicaid rate to 100% of Medicare
    - xii. Include CHC and school based clinics\*
    - xiii. Auto-screening and enrollment in Medicaid for uninsured at point of service as well as on-line screening for eligibility
  - xiv. Workforce development (reference Tonya Court report)
  - xv. Public education on living wills\*
- b. Cost Containment (\*\* indicates potentially quality improving initiatives)
  - i. Pooling of risk

- ii. Self Insurance
- iii. Minimum medical loss ratio
- iv. Pay for performance\*\*
  - v. Reduce cost shifting for uncompensated care
- vi. Value based plan design\*\*
- vii. Expanded IT\*\*
- viii. Medical Malpractice
  - ix. Revise consumer protections and insurance mandates to align with evidence based and value benefit design under aegis of Trust
  - x. Care coordination\*\*
  - xi. Reduce admissions for ambulatory care sensitive conditions
- xii. Universal
- xiii. CON

### III) Coverage

- a. Satisfied customers can keep existing coverage
- b. CT Health Partnership (state employee pool)
  - i. Provide parallel options to individuals and businesses
  - ii. Make options attractive by incorporating Value based design (public, transparent process)
  - iii. Expand benefits to include oral health and mental health
- c. Maximize federal participation-- convert SAGA to Medicaid (CMS waiver required)
- d. Enrollment in coverage
  - i. Through Trust for new coverage options
  - ii. Automatic enrollment in HUSKY, SAGA at point of service for eligibles
- e. Shared responsibility as the underlying principle: individuals, employers, and government all play a role in achieving our goals.

### IV) Financing based on shared responsibility

- a. Business Contribution: employer share of health costs of individuals
- b. Individual contribution: share of health costs based on sliding scale and affordability index
- c. Government contribution to support affordability
  - i. Existing revenue streams
  - ii. Sin taxes
  - iii. Bonding for specific initiatives
  - iv. Additional federal funds

Tom Swan asked for comments on the framework.

Steven Frayne felt that the intent of increasing the rates of Medicaid to 100% of Medicare is good, but that the language is not suitable.

Ludwig Spinelli asked how many models Dr. Gruber might be willing to model for the Authority.

Tom Swan responded that Dr. Gruber would not be able to look at a large number of models.

Tanya Court asked if a State agency already performs the tasks that are described in the framework. The Authority must also look at a single payer system.

Tom Swan responded that the consultants from the Urban Institute would look at the trust idea and where it has been implemented elsewhere.

Eric George asked if the Authority has been in consultation with the Office of Health Care Access regarding the potential overlap or rearranging of other agencies that could be the result of the trust.

Tom Swan noted that representatives of the Department of Social Services (DSS) and the Department of Public Health (DPH) both serve as ex-officio members of the Authority.

Eric George asked if the modeling that would take place going to involve actuarial analysis and what contributions would be needed to implement the program. A significant portion of the plan relies on an employer contribution that could be invalidated by the federal government.

Tom Swan responded that the San Francisco healthcare system has survived a challenge in the district courts. It should be possible to pass a plan that can pass a legal challenge.

Leo Canty addressed the framework and described it as a good initial step towards a healthcare plan for Connecticut. There are a number of systems and organizations that are working to deliver healthcare in Connecticut but we have nothing that coordinates all of them. We need to make a commitment that Connecticut will have a culturally competent delivery system and that will help to eliminate racial and ethnic disparities. Workforce development must include recruitment of people of color to improve cultural competency.

Henry Jacobs noted concerns with the illness of the healthcare system which will make it harder to provide healthcare to a larger number of people. It takes about a month for a patient to get an appointment with a patient. DPH may need to be involved in the planning but there must be some oversight during the administering of the new healthcare system.

Jamie Stirling asked about bringing private sector employers into the suggested trust.

Tom Swan responded that it should be an option and that there would not need to be a mandate on employers to join the trust.

Jamie Stirling commented that the more flexibility that the trust had in creating plan designs, the more likely it would be in attracting municipal employers and private sector employers.

Mickey Herbert reminded the Workgroup that there were only three voting members of the Authority present at the meeting and no votes had been taken yet. Therefore, it is not clear that the Authority will support the public trust that has been described at the meeting.

Tom Swan clarified that there had been no vote and that it was a proposal that had been created by the Co-Chairs.

Paul Grady discussed the Universal Health Foundations modeling that took place several years ago and a document that describes it is available on their web site. One piece of data that would be useful is the present value of retiree medical benefits for state employees.

John Farrell responded that what is paid in the State budget for retiree health plans is 350 to 400 million dollars, and the liability number is 21 billion dollars.

Steven Frayne asked if someone would examine the execution of the proposed plan.

Tom Swan described the trust as a reorganization of state plans in a way that assists private employers who chose to participate in the plan. At the same time it would provide universal healthcare.

Steven Frayne clarified that legislative leadership could put the plans in statute but could not execute them. State agencies would then have to execute those statutes. Steven Frayne noted his skepticism that the Agencies may not be willing to execute the new law. There may need to be an oversight committee to ensure that the proper action is taken.

Karl Ideman asked for more details on some of the proposals to get a better idea of the financing and cost that would be associated with the new system.

Eric George asked what the timetable was for executing the actuarial analysis.

Tom Swan responded that the data sets have already been built and the analysis should be available soon.

Eric George asked if the report going to show what each separate component of the program would cost, as well as the cost savings, and the necessary individual employer and individual contributions.

Tom Swan responded that he would prefer to see the report presented that way, but couldn't guarantee that.

Andrew Gold informed the authority that anything that impacts the ability to provide consistent plans across the national population would be something that would make it extremely difficult to continue offering plans to some or all of the population. The plan that has been suggested may make it difficult to continue to operate in Connecticut. ERISA works because it allows for a consistent plan design. That is critical and anything that could impact ERISA could impact the business in Connecticut.

Eric George commented on the ERISA issue and described it as "muddy." It is an area that is controversial and it will be difficult to pass changes to the ERISA system through congress. Scaling back or streamlining ERISA may not be easy. Granting states more flexibility is an area that is not clear.

Tom Swan clarified that there would be an implementation and a start up phasing of the plan. The Authority must provide a proposal that meets the Institute Of Medicine Principles, as the Authority is charged to do.

Eric George clarified that the Hawaii ERISA challenge was not successful and that was because they have an exemption from ERISA.

Paul Grady asked for the framework to be expanded and examples of where each proposal has actually succeeded in the real world, and finally, a financial explanation of each proposal. We also need to consider obstacles to implementation.

Tanya Court asked about the hold on the money that had been reserved for the HealthFirst Authority.

Tom Swan responded that a transfer from DPH to legislative management was proposed last year but it had not been signed by either of the minority leaders. That meant that the money could not move from DPH so now the HealthFirst Authority is moving through the DPH procedures to make sure the money is spent properly according to state spending guidelines.

Victoria Veltri offered a presentation on consumer protections and mandates under state and federal law. The Office of the Healthcare Advocate (OHA) is a consumer advocate itself. The OHA has three primary responsibilities: 1) helping people with issues with the managed care plans 2) outreach as it

pertains to health insurance rates, and 3) proposing legislation when something needs fixing on a systemic basis.

Some will say that the proposals include mandates but those can also be viewed as consumer protections. They can be divided into two categories: Coverage protections, and process protections.

Federal laws do not preempt the better protections that we have under state law for fully insured plans.

In addition to federal protections there are Connecticut consumer protections which is what many people think about when they think about mandates in Connecticut.

Victoria Veltri also offered the Workgroup a summary of consumer protections in Connecticut.

Tanya Court asked for a summary of how plan design is determined in the state of Connecticut. The role of the Department of Insurance is to determine whether those plans have the mandated coverage. What has been proposed as healthcare reforms is that the Trust would design the plan design and make sure that all insurance would comply with whatever new plan design is developed.

Tom Swan asked Mickey Herbert and Paul Lombardo respond to the second half of the question. The options provided to the public sector would incorporate the value based health plan design on evidence based medicine. Therefore the trust would determine that benefit package. The regulation of the private sector marketplace beyond that would be up to the Insurance Department.

Tanya Court clarified that she found the role of the Insurance Department a bit vague in determining the plan design.

Mickey Herbert raised the question: "how many of these mandates are necessary in order to provide quality care to those who chose to receive it." The list of mandated benefits may not be necessary. Providers will provide those benefits regardless of mandates because they are effective coverage. There are other mandates that may not be necessary and if we are more flexible we may be able to lower insurance premiums by 15%.

Paul Lombardo discussed the Insurance Department's perspective. The Insurance Department is a regulatory agency with a responsibility to implement the insurance statutes and regulations. The Insurance Department is involved with the Legislature when legislation is considered with a mandate on the Department.

Tanya Court asked if the Insurance Department has to do with what carriers are filing with the Department and determining their compliance with Connecticut state law. She asked if it is the responsibility of insurance companies to determine plan design.

Paul Lombardo agreed that was the case.

Tanya Court asked for clarification that there is no one single group to determine a single plan design that encourages people to stay healthy.

Paul Lombardo clarified that it is not the Insurance Department that is responsible for determining that plan design if that is the case.

Jamie Stirling described a resurgence of interest in companies between 75 and 300 employees looking at self-funding plans for the first time in several years. They are saying that the new mandate of covering to ages 26 as the tipping point.

Victoria Veltri asked how it increased the employer's costs if the full rate is still being paid by the dependent.

Jamie Stirling replied that those who keep the coverage are those with high claims.

Eric George suggested that he is not aware of state analysis of what the impact to premiums is on mandates. It is an area that has been debated in the Legislature for a long time. One thing that has been touch on by several speakers is the area of making health insurance more affordable to small companies.

Victoria Veltri responded that there is agreement that there needs to be a study of premiums and their effect on mandates and it needs to be an independent study.