

HealthFirst Connecticut Authority

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Meeting Summary

Wednesday, January 16, 2008

9:00 AM in Room 1C of the LOB

The Following Members were present: Tom Swan, Margaret Flinter, Fernando Betancourt, David Benfer, Sal Luciano, Franklin Sykes, Mickey Herbert, Kevin Lembo, Brian Grissler, Commissioner Thomas Sullivan, and Martha Judd representing David Benfer.

Also present were: David Krause representing Nancy Wyman.

The following members were absent: Commissioner Michael Starkowski, Louis Lista, Michael Fedele, Commissioner Robert Galvin, Lenny Winkler and Sharon Langer.

Tom Swan announced that the Business Council of Fairfield County has expressed an interest in working with the HealthFirst Connecticut Authority as it moves forward. He expressed his intent to bring people from other states to present information to the Authority.

Margaret Flinter corrected a statement that she had made at the previous HealthFirst meeting regarding membership on the Committee. She had said that any member who had missed three meetings would be automatically dropped from the Authority. However, that rule applies to the Primary Care Access Authority not to the HealthFirst Connecticut Authority. If a vacancy were to open, there would be a thirty day window for the appropriate authority could appoint a member. If a new selection is not made in thirty days, the chairs would have the responsibility of filling the vacancy.

A motion to approve the minutes as amended was made by Mickey Herbert and seconded by Kevin Lembo

The motion passed.

Tom Swan reported that Academy Health Care has offered to hire a consultant to facilitate the HealthFirst Authority meetings and the workgroups meetings.

David Parrella expressed his support and stated that Academy Health Care would be able to find a suitable administrator.

Tom Swan stated that they were looking at Charles Milligan as a potential administrator and described him as a person who had worked with the Lewin group and also had been a leader within the Medicaid program in New Mexico.

Kevin Lembo asked for clarification on potential problems with the gift ban.

Tom Swan responded that he had met with the Department of Public Health and the Office of Legislative Management and as long as the contract is worded properly, they would be able to sign off on the agreement with Academy Health relatively quickly.

Fernando Betacourt asked if Academy Health had a contract with the state with regard to provisional services.

Tom Swan suggested that based on preliminary hearings it looks as though it should be possible to use Academy Health as a resource.

David Parrella asked if the proposal could be sent to the State Ethics Committee. A formal review from the State Ethics Committee should ensure that the proposal meets the standards that they are interested in achieving.

Tom Swan said he would consult legislative staff to determine what the proper actions would be.

A motion was made and seconded to pursue the use of Academy Health Care services.

The motion passed.

Margret Flinter gave an update on the progress of the workgroups and the Cost, Cost Containment and Finance Workgroup will meet on January 22nd, and the Quality, Access and Safety Workgroup will meet on January 31st.

Tom Swan asked that additional recommendations for members to the two workgroups be given to the chairs. The intent of the two workgroups is to create an inclusive group of experts in the health care field.

Stan Dorn introduced his presentation as an overview of some of the policies that were developed for the Foundation that estimated the effects and changes to the health care system if everyone in Connecticut had health insurance.

Stan Dorn reported that the first thing the Urban Institute worked on was a map of the health care system in Connecticut. There were two rounds of policy analysis. The three ways to expand coverage as

concluded on by the Urban Institute were, (1) A single plan that serves all state residents, (2) A health insurance purchasing pool that covers everyone that's not insured by their employer, (3) Expansion of Medicaid and HUSKY and add tax credits to subsidize coverage for people that are uninsured.

In the second round of work, the Urban Institute looked at a plan that would not only cover everyone but would also meet the Institute of Medicine principles in terms of continuity of care, equity, sustainability and finance. The group looked at two options, (1) A single, self-insured plan that would serve everyone in the state and (2) A health insurance purchasing pool with competing private insurance plans that everyone in the state could chose from.

In the first round, the plan called for an employer system that would require every employer to contribute to health care for their workers as a percentage of the payroll. Feedback on that plan suggested that small employers would need special care.

As a result, in the second round the Urban Institute lowered the payments asked from small employers. A more sensible approach was to take the payroll amount that is the average for small firms and for each dollar over a certain threshold amount, you would pay a certain amount back to healthcare coverage.

The second change has to do with the health insurance purchasing pool. In this round the Urban Institute looked at a plan that would cover everyone and ignored employer sponsored insurance. The benefits that would be offered were comprehensive benefits similar to the benefits employers offer today. Low income citizens would get extra help because they are unable to pay for services out of pocket.

The Urban Institute estimated that both of these strategies would save money per capita. Average spending per insured person would go down about 15.5% as a result of reduced administrative costs, there would be more leverage for the payers negotiating with several providers, and you would be able to use system management in the form of electronic health records and reduced duplication of services. The Urban Institute estimates that there would be a 9.4% per capita savings.

Both proposals eliminated the uninsured in Connecticut. Additionally, although all employers would have to pay, the total amount that employers pay would go down substantially and household income would go up by more than a billion per year. State general funds would go up by a small amount, and there would be about 1.5 billion more in federal funding that will help make this system work.

Stan Dorn reported that using a state economic model and applying the changes in the health care system as proposed, there would be small positive impacts. There would be additional jobs, and state GDP would go up slightly. This would be due to lower labor costs which betters the economy.

He added that in the second round of planning it was suggested that employers be prevented from offering coverage and should instead drop coverage to push people into insurance pools. The positive effect of this is the more people you have in pools, the more you can limit insurance premiums. This also increases portability of insurance. This plan would also increase the amount of federal dollars coming in which lower the costs for people in the state.

Stan Dorn stated there are several problems to this plan.

- 1.) The legal barrier that prevents states from directly regulating the provision of employee benefits.
- 2.) The danger that employers will stop offering coverage.
- 3.) The danger that employers will encourage older or less healthy workers to go onto the state plan. This would force premiums to rise.

To address the aforementioned challenges, the Urban Institute created a plan that would mandate employers to pay a certain amount based on payroll with credit being given against the charge and federal dollars would also be credited against the tax.

It is possible to do systemic health care reform in this state in a way that covers everyone and significantly benefits providers, families, and businesses. A few businesses will actually lose profits due to these changes but the vast majority would profit from them.

Fernando Betancourt asked if all the variables were taken out and you assume more productivity because you have more people with access to the health care system, why is that not included in terms of higher productivity and higher gross domestic product.

Stan Dorn responded that would fall under additional gains.

Fernando Betancourt stated that one could conclude that the Urban Institute plan would be even better for the private sector.

Stan Dorn agreed and used chronic illness as an example of a drain on health care costs but an even bigger setback for productivity.

David Parrella questioned that assumption that the Urban Institute made that the federal government would match funding for Medicare. He noted that his experience was that the current administration does not generally match funding.

Stan Dorn said that he had spoken to several people at CMS who had advised him that if the employer makes a premium payment it would not be match-able. The approach we had structured would look more like a tax on employers. This would not be a tax tied to this particular employer receipt of services. He cautioned that this is a plan that would be more likely to be effective after January of 2009 because the current administration has not allowed this type of change to take place.

Brian Grissler asked if he included undocumented immigrants and their access to the system especially in areas like Stamford and other urban areas.

Stan Dorn said that the choice that you have to make is between limiting yourself to what the federal government matches in which case you must limit care to legal permanent residents or immigrants who have been here for five years, or do you go beyond that to use state-only dollars to provide care for legal immigrants who have been here less than five years and undocumented immigrants. The second question you must ask is what kind of safety net do you want to provide? If you have a universal coverage system the reality is some people will fall through the cracks, some immigrants, some people

with mental illness and some people who move around. This means a safety net system that is adequately funded is necessary to care for these groups.

Brian Grissler asked if the increase in the reimbursements may have to occur from the Medicaid reimbursement which is sometimes as much as 70% of the cost structure.

Stan Dorn responded that he had and reimbursement rates would rise to commercial level as a result of his proposal.

Franklin Sykes asked if the reforms are based on employer sponsorship, and therefore you must be working to be insured.

Stan Dorn responded that everyone in the state would have health coverage regardless of employment status. Some funding would come from employers, some funding would come from individuals and some would come from government.

Franklin Sykes asked what would happen to people that may be left out of the health care system if it was reformed, and who would represent them.

Stan Dorn said that the system would include most people and we should fund a safety net program.

Kevin Lembo asked if there was any public opinion with regards to people's willingness to give up employer sponsored coverage.

Stan Dorn responded that polling shows that people believe the health care system need change but most people also like their insurance and asking people to give up their healthcare will generate a lot of opposition. But there are good reasons to try and generate reform of the health care system.

Sal Luciano noted that NPR did a report on wait time in hospitals and they reported that between 1997 and 2004, wait time in hospitals doubled. For minorities the wait time was 14% greater and women had a 5% longer wait time. Sal expressed his belief that the suggested reform would help reduce wait times and save money.

Brian Grissler suggested that implies that there is a choice on the part of hospitals in terms of what they are consciously doing on a daily basis. In the absence of a primary care network and safety net, the emergency department becomes the de facto provider of choice and that overwhelms hospitals. He added that the suggested inference that hospitals are intentionally understaffing emergency departments is not accurate.

Stan Dorn responded that he knew that in other locations around the country there were hospitals that deliberately reduce the number of emergency department beds on certain nights so that they don't get gunshot wound victims that would be classified as uncompensated care in their hospital emergency departments.

Martha Judd added that during the evening hours, nights and weekends, the ER's are busier because no one else is providing care during those hours.

Brian Grissler added that the mental health care system is broken and that it is a factor in ED's being overwhelmed.

Margret Flinter added that we must find ways to motivate people to do the things like electronic health records, and to get people to stay open in the evenings and on Saturdays, which is not likely to happen without incentives.

Stan Dorn explained that his model looked at what the cost of average employer based insurance is today and looked at system efficiencies and administrative costs and believe that those could bring down costs somewhat. He added that the reimbursements that Margret Flinter described were not discussed by the Urban Institute. He stated that the model was conservative in looking at macroeconomic activity, looking at how everyone would be guaranteed a primary care provider and how care is managed and coordinated.

Commissioner Sullivan noted that we are 48th in the nation in terms of our medical malpractice claims cost and so cost drivers may have been overlooked.

Stan Dorn stated malpractice reforms were not looked at and that a study on claims shows that differences in states with different claim levels and different premiums shows relatively low impact on changing malpractice. He added that the big drivers of cost are chronic care management, inefficiencies and the lack of evidence behind the prescribing of medications.

Mickey Herbert expressed concern with the possibility of creating a system such as Stan Dorn has described. He noted that 60% of the American public has employer sponsored insurance. He added that the number is much higher in Connecticut and the recipients of that coverage are very happy with it.

Mickey Herbert stated that debate in the Legislature has gotten into the issue of whether or not municipalities should be required to participate into the State Insurance Pool. He stated that those municipalities who had experience with the issue were opposed to getting into the pool and this may mean that there is not enough political traction to pass this sort of legislation. He stated that another issue is the Office of Policy and Management's (OPM) estimate that the legislation would cost close to \$17 billion dollars which is far more than Stan Dorn had suggested in his presentation. He also expressed disagreement with Stan Dorn on the issue of malpractice claims costs.

Stan Dorn responded that risk selection was an issue but not an unsolvable problem. You could say that whatever the rating rules were inside the pool are the same rating rules outside of the pool. So to the extent that group rates in the state based on age and industry, those variables will be taken into account inside and outside of the pool. The bill that OPM scored had no financing component compared to the plan that Urban Institute created that had financing mechanisms. He stated that in terms of defensive medicine, research shows that it may not be a big cost driver and in terms of Medicaid to commercial rates, that would be costly and that cost was factored into our analysis. Stan Dorn agreed with Mickey Herbert's point that government does not do a good job of managing Medicare and that the fees for service costs are higher in Connecticut than in other states.

Brian Grissler commented on the fact that we live in a state with a high cost of living that leads to higher input prices in the hospitals. He asked Stan if he had factored in the potential of being seen as a great place to live and work, and how that may create an influx of people who wish to move to Connecticut?

Stan Dorn responded that he would suggest a 6 month waiting period or longer as a way of deterring people from moving across state lines simply for medical benefits.

Tom Swan noted that the issues that had been raised would be considered by the workgroups. The issue of malpractice will be addressed by the quality, access and safety workgroup. He added that prevention of medical errors and malpractice is the best way to keep premiums down.

Tom Swan stated that administrative overhead cost is a much bigger cost driver in the state of Connecticut than in the rest of the country and the workgroups will also address that issue.

Stan Dorn stated that his opinions were his alone and not the opinions of the Foundation.

Margret Flinter reminded members that the Next meeting is February 20th at 9:00 AM.