HealthFirst Connecticut Authority

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Meeting Summary

Thursday, April 3, 2008

9:00 AM in Room 1C of the LOB

The following members were present: Margaret Flinter, Tom Swan, Mickey Herbert, Sharon Langer, Michael Critelli, Sal Luciano, Nancy Wyman, and Fernando Betancourt,

Also present: Victoria Veltre representing Kevin Lembo, Martha Judd representing David Benfer, and Paul Lombardo representing Commissioner Thomas R. Sullivan,

The following members were absent: Lt. Governor Michael Fedele, Brian Grissler, Lenny Winkler, Commissioner J. Robert Galvin, Commissioner Michael P. Starkowski, Teresa Younger, and Franklin Sykes.

Tom Swan welcomed members to the meeting. He introduced Randy Bovbjerg and Barbara Ormond, facilitators engaged to support the work of the Authorities. Tom Swan informed the Authority that resources have not been made available by The Office Of Legislative Management to pay for an inventory of the primary care systems in Connecticut.

Margaret Flinter gave an update to the Authority on the progress of the Quality, Access and Safety Workgroup, which has examined electronic health records, health information technology, patient safety, and the role of health care reform in advancing electronic health records and health information exchange.

Tom Swan updated the Authority on the activity of the Cost, Cost Containment and Finance Workgroup. During the previous meeting, three presentations were given that focused on the issue of cost containment. Andrew Gold presented the health care innovations that have been incorporated by Pitney Bowes. Michael Brown reported on the ways that Aetna had been promoting innovations and

utilizing information and planning. One problem the workgroup has already encountered is a lack of information.

Margaret Flinter asked for the members input on the structure for coming to agreements as we move forward. Members agreed to continue a structure of trying to reach consensus, but registering disagreements where they exist. Margaret reviewed the common recommendations she had pulled out of a number of earlier task forces and commissions. Accelerating the deployment of electronic medical records, health information exchange and health information technology had been widely agreed upon. The second issue widely agreed upon is the need to invest in wellness, and to do this we must address smoking, obesity, and the culture of bad health habits. The third issue that seemed to find overwhelming agreement was the issue of Medicaid, increasing the enrollment of those eligible for Medicaid and increasing participation of those who could provide care but are not under the current system.

Margaret Flinter stated that this meeting would be devoted to the Massachusetts healthcare reform experience, with a presentation by John Holohan of the Urban Institute. Margaret Flinter reminded the Authority that the Legislature has asked the Authority to investigate four types of healthcare systems: single payer, pooled plans, extensions of public and private insurance, and the universal primary care.

Margaret Flinter introduced Randy Bovbjerg who reviewed the Institute of Medicine (IOM) five principles of healthcare coverage: Healthcare coverage should be 1.) Universal 2.) Continuous 3.) Affordable to individuals and families 4.) Health insurance should be affordable and sustainable for society, and 5.) Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

1.) For universal coverage to exist, there must be a motivation for people to get and keep coverage, a definition of coverage, a healthcare infrastructure, assistance for low-income and high-risk residents, and a sustainable funding mechanism.

2.) Continuous Coverage requires attention to transitions between coverage options, funding mechanism(s) that minimizes the risk of cutbacks in the future, and attention to cost.

3.) Affordability is influenced by income, health status, structure of coverage as well as premiums, and benefits

4.) Affordability for society requires consideration of how much the state will have to pay, how the state will fund the plan, how the funding will be maintained in the face of yearly state budgets, and cost containment and efficiency will be critical for success.

5.) Affordability and sustainability for society will depend on how much of the share is borne by the state, how the state share is funded, how the funding is maintained in year-to-year budget changes, and cost containment and efficiency will be critical for sustainability.

The enhancement of health and well being applies to existing coverage as well as expansions. Financing should provide incentives for caregivers to provide efficient, high value care and residents to take responsibility for their health and use care wisely. Policies that affect caregivers should be attractive enough to induce both reasonable availability of care and willingness to undertake value enhancing

activities. Providers and residents need systematic support including information, oversight and feedback. Establishing and maintaining the correct price signals will contribute to achieving high-value care.

Michael Critelli asked that the committee make Randy Bovbjerg's latter points the operative principles of the HealthFirst Authority. The IOM principles, as explained at the beginning of the presentation, were incomplete.

Sal Luciano noted that the current criticism of medicine is that we take care of the injury, not the person. A similar criticism could be made of aspects of our healthcare system in Connecticut. For example, a hospital shutting down may save a particular city money, but it will not save the people of Connecticut money. Healthcare must be looked at in the bigger context of savings for the State.

Mickey Herbert Commented that the negative turn of the economy will impact our efforts. Economic pressures could affect the suggestions the HealthFirst Authority offers to the Legislature.

Nancy Wyman suggested that because the economy is cyclical, and despite the slowing of the economy today, the work of the HealthFirst Authority will be relevant and should not get in the way of improving the healthcare system in Connecticut.

Sal Lucciano reported that over the last eight years, the number of uninsured has risen by nine million people, and we have five million more people in poverty. The median income of the American family has gone down about $1,100. These changes occurred during a time of economic boom.

Margaret Flinter referred the Authority to a story in the Hartford Courant that reports the death of three people in Connecticut that could have been prevented if they had health insurance. This timely story should serve as a reminder of the importance of our work.

Randy Bovbjerg introduced the guest speaker, John Holahan, who is an expert in Medicaid, health insurance and reform. He led the "roadmap to coverage," effort in Massachusetts.

John Holahan reported that Massachusetts may have seemed to be an ideal place for healthcare reform. Massachusetts had a low insurance rate, it was a relatively wealthy state, it had an uncompensated care pool that had funding coming from the business community and federal government, but the politics there made it very difficult to pass healthcare reform and the plan came very close to failing in the State Legislature due to many complications. The Safety Net Hospitals were willing to fight against universal coverage to prevent a loss of profits. Hospitals and physicians were generally supportive of the legislation but fought hard for a rate increase for hospitals and doctors. Insurers were opposed to a large purchasing pool, businesses were against employer mandates but also wanted non-offering employees to pay into the pool to help support it. Governor Romney and the Federal Government were against Medicaid expansion, and finally, most players were against new taxes. There were pressures on the Legislature to act to fix the healthcare system. One of these pressures was the potential loss of $385 billion of waivers if the waivers were not renewed. The second force pushing legislation forward was the rising costs of the uncompensated care pool. The costs in the pool were rising every year for two main reasons, a slow economy and healthcare costs were increasing. Two groups pushed for ballot initiatives that would push the state to universal coverage.

Blue Cross Blue Shield (BCBS) of Massachusetts Foundation played a role working with business leaders to explain what health reform would look like and keep them at the table. BCBS did public education and helped keep the media involved by holding statewide summits. Most importantly, small groups of business leaders and providers were offered the opportunity to engage each other and debate their concerns or interests in whatever healthcare changes may occur.

Analysis of data was important to the Massachusetts plan. The current population survey of Massachusetts was used. Data on coverage by income was used as well. The costs of caring for the uninsured and who pays that money was determined. The Massachusetts legislature looked at the costs of several options. Incremental reforms would leave many people uninsured. It is important to note that incremental reforms do not get you to universal health care. When mapping out an employer mandate model we discovered there would be significant costs on businesses, especially small businesses. There are also issues with ERISA that would complicate employer mandated coverage, and even an employer mandate leaves you well short of universal coverage. We looked at individual mandates and showed that the costs were not much higher than under the employer mandate model. Businesses would not drop coverage because there would be an incentive to provide coverage. Most importantly, government costs would be relatively low in comparison to the state budget. The costs approached 2 billion for an individual mandate. The benefits of coverage would exceed the costs based on IOM principles on the value of a year of healthy life and studies that show the benefits of additional years of healthy life.

In a study of the macroeconomic effects, we found that the effects would be slightly positive. The new taxes and new employer payments would have adverse affects but the money would be distributed into the healthcare sector and that adds to GDP and jobs. The healthcare industry tends to be more labor intensive which produces more jobs, and the healthcare dollar tends to be spent within the state.

Mitt Romney proposed an individual mandate, a connector where people could go to get coverage and income related subsidies. He opposed an employer mandate and any new taxes. He also opposed Medicaid expansion.

The Senate President was opposed to the plan. His goal was to protect the safety net hospitals to make sure that they did not lose out. He was in favor of some kind of a Medicaid expansion but opposed employer and individual mandates.

The House wanted a strong employer mandate with a high payroll tax, an individual mandate, subsidies where people could buy coverage within a connector structure and a broad Medicaid expansion.

Because of the large differences between the proposals, it appeared that the plan would fall apart. The democratic leadership in the house along with the business community and the Blue Cross Blue Shield Foundation were able to save the plan by offering a compromise: an employer mandate with a very small penalty. The legislation passed almost unanimously.

John Holahan explained the agreement that was reached in Massachusetts:

- The legislature agreed upon a Medicaid expansion for children. There is an income related subsidies provision in the plan, but only up to 300% of the federal poverty line (FPL).

- The individual mandate was not specified in the legislation and was addressed by the creation of a "connector." The connector applied only to small businesses with fewer than 50 workers. This was the place where people could determine if they were eligible for subsidized care. The connector determined what the benefit package and subsidy schedule would look like.
- The safety net providers kept access to Federal and State funds; this access will be phased out as more people get coverage.
- Commonwealth care was established for people under 300% of the FPL and offers subsidized products. Only the plans serving Medicaid before the agreement was made are eligible to sell plans in the Commonwealth Care.
- Hospitals and physicians were awarded healthy rate increases.
- Insurers and providers that did not favor a large purchasing pool were considered when the pool was limited to businesses with less than 50 workers.
- The business community was faced with a mandate but the assessment is very small.
- Those who wanted no tax increase were pleased that there was no tax increase.
- Consumer advocates were pleased with the uninsured coverage.

The various compromises helped consensus building but did not address some aspects of the healthcare system and its sustainability. The affordability schedule and the benefit package were not addressed in the legislation but have been since the passage of the legislation. Cost containment was not addressed and a commission has been established to deal with cost containment. They did not want to extend subsidies above 300%. A provision was created that exempts those people if premiums in the least expensive plans that are approved by the connector if it exceed some percentage of income (roughly around 8%). If you are eligible for this provision you can appeal and be exempt from the mandate. The estimate is that 60,000 uninsured are exempt from the mandate. The waiver will need to be renewed; if it is not, there will be a serious fiscal issue. Higher enrollment in Medicaid and in Commonwealth Care have driven the cost of healthcare up. Scheduled rate increases to hospitals and doctors also put strain on the healthcare system. The final budget issue is the recession. Sustaining the system in Massachusetts will be more difficult due to the economic slowdown.

Sal Luciano asked about the differences between healthcare plans.

John Holahan explained that the benefits do not change significantly between plans but the deductibles do. Gold plans have higher deductibles than other plans, the bronze plans have deductibles of $2,000 for an individual and $4,000 for a family without out-of-pocket caps of $5,000 and $10,000.

Commissioner Sullivan asked if the Massachusetts small business market is community rated.

John Holahan replied that it was.

Mickey Herbert expressed concern about the sustainability of the healthcare plan in Massachusetts. He asked for elaboration of the issue of cost containment and what Massachusetts may do to contain healthcare costs.

John Holahan replied that the cost containment methods that are being considered are chronic care management, electronic medical records, a center for effectiveness to evaluate new technologies and added the only thing that has been successful has been using the power of a large buyer to control the

revenue flow to providers. The notion of expanding the connector to put pressure on insurance companies to negotiate with providers was also discussed.

Mike Critelli suggested that if you add a large number of people to a system but do not increase the number of providers there must be some accounting for what happens at the service levels. He asked if there was any modeling done in Massachusetts of the effect of increasing the number of people without increasing the number of providers. Michael Critelli asked whether the extension of coverage created any shortage of physicians and whether there are any service or quality standards addressed in the Massachusetts coverage plan.

John Holahan replied that there had been no such modeling done because Massachusetts is a provider-rich state. A lack of providers is an issue in other states.

Mike Critelli asked if the increased GDP generated by the healthcare system translated into government revenues.

John Holahan replied that was not the case, but the significance of the GDP modeling is that it shows that jobs would not be lost by that change in the healthcare system.

Leo Canty asked if Massachusetts and Connecticut have comparable Medicaid reimbursement rates.

John Holahan replied that Massachusetts physician and hospital rates are low relative to Medicare.

Margaret Flinter asked if there was no longer a question of pre-existing condition with regard to enrollment in Commonwealth Care.

John Holahan replied that there was not.

Margaret Flinter asked about the preventative services offered in Massachusetts.

John Holahan reported that even in the high deductible plans there were a certain number of preventive services that are covered with no co-pay necessary.

Martha Judd asked if the heavy enrollment in the bronze level plans has impacted the safety net providers and their bad debt expense.

John Holahan reported that there was not a significant impact on the safety net providers. People below 300% of FPL do not pay the higher deductible rate.

Randy Bovbjerg added that there was continuing support for the safety net program and those enrolled had no previous insurance.

Sharon Langer asked if it was true that in Massachusetts all providers are required to participate in Medicaid.

John Holahan responded that was not the case.

Sharon Langer asked what percent of providers in Massachusetts participate in the Medicaid program.

John Holahan replied that he was unaware of the percentage.
The meeting was adjourned at 11:00 AM.