

**HealthFirst Connecticut Authority, May 1, 2008**

**Draft comments on possible reform options**

**5. Universal Entitlement to Primary Care**

Definition of primary care [in medicine] vs primary care services [for insurance]

System capacity (cross-cutting issue, RFP will address) [there are too few primary care doctors already]

How would it operate at the practice level?

How would the state relate to providers?

Reimbursement and cost shifting [low reimbursement rates to primary care providers could result in cost shifting to other payers]

Annual spending caps?

Need to disconnect from annual cycle because medicine isn't annual [payment cannot be held up in annual issues of state budgeting, need another mode of operations]

Management of non-primary care services

Connections between primary and non-primary care providers [referrals, continuity of care]

How to not disrupt care patterns

Participation by specialists [still important]

Role of reimbursement levels [remains important; not true access without good participation]

Who is a primary care provider? [all/most physicians are certified/trained in primary care but many are also certified as specialists and practice very little primary care.]

Changing attitudes of physicians toward after-hours coverage [affects primary care capacity and could hamper true access to primary care]

CT-specific family practice issues [because CT is replete with specialists, e.g. for OB, hard for primary care physician to practice to full capacity of training; many might be tempted to relocate to more favorable environments]

Payment system – influences primary care providers movement into specialty care [a root cause of shift in physicians to specialty practice]

Different expectations about practice among new physician graduates [who want more regular hours, hence overall access by patients is reduced during off hours]

Impact of increased access to primary care on demand for diagnostic/specialty care [specialty services will need to expand because more primary care service will lead to referrals]

State licensing of non-physician primary care providers [needs to be rethought as a way to expand primary care access, given the current state of physician supply]

How to incent additional primary care providers [needs to be a consideration under any reform]

Concern with full continuum of services (e.g., home health, acute care) and the impact on hospitals [is important not to think of primary care in isolation]

Evidence-based medicine needs to be incorporated [into any reform, to achieve desired improvements in cost and quality]

#### **4. Regionally organized care**

Why limited to employees?

Could cover everyone [including individual/non-group enrollees]

North Carolina model – organization of physicians

Undocumented immigrants (cross-cutting issue)

Would the state become a magnet? [if it allowed easy access to coverage or care; could be of an issue for other options as well]

Need to educate residents about [appropriate] use of system [this is true under any system]

Role of non-physicians [cross-cutting issue]

Two-tiered care

Reality vs perception

Crowd-out [provisions] leading to people going “bare” in order to qualify for new coverage [i.e., crowd-out will occur if people are motivated to go without coverage for a time in order to qualify]

Fixed costs of ER [these costs won't go away if coverage is improved so that fewer relatively healthy people go to ER; the high fixed costs remain, and the remaining people in ER cost more each. So the system might not get anticipated savings. Commentator—but big savings could come from avoiding preventable inpatient stays initiated thru the ER]

Plan design – simplicity facilitates understanding

### **3. Insurance choice**

Could include non-workers

Structure for enrollment and premium collection [would need to be determined]

What can we learn from FEHBP?

Rich benefits in the state plan [could make expansion expensive]

Adverse selection could pollute the pool [raising rates for existing enrollees]

As designed, [the initiative would create a] cartel

Start-up costs could be huge [not small, as stated in the options summary]

Danger of erosion of benefits [in response to rising costs and adverse selection]

Is state plan “rich” or have [the benefits in] other plans deteriorated [relative to it]?

Selection [is likely to be an issue], [the plan could become a] risk magnet if individuals allowed to join.

Benefit design [should] encourage healthy behaviors

Risk profile of current population [we need to know it before adding proposing the addition of new enrollees]

Those people who represent adverse selection are those that need care and should be in care and management [cross-cutting issue]

## **2. Bolster employer-based system**

ERISA concerns

Will there be national change in ERISA [that could affect the design of reform in CT]?

Would individual mandate help with ERISA issue?

Advantage of employer-based system is ability to change benefits to reflect needs, experience, new technologies [which could help with cost containment, quality]

With change in state regulation, could include individuals [in such a plan]

Business provision of primary care [should be taken into account, since it could be affected]

## **1. Universal entitlement of publicly financed coverage**

Non-residents? Undocumented? [who should be included?]

May not be politically feasible or legal

Departure of providers and insurers [is possible, driven by fears about such an initiative]

Control costs by controlling unit costs but not by controlling utilization

Concern about entrusting payments to government (federal and state) that has historical underfunded providers

Concern about physician participation [cross-cutting issue]

Would private option remain?

[if not, there could be] Border crossing to access care not provided well in the system

Effect on business climate – [could affect the] location of businesses in CT, particularly those with multi-state operations

People's belief in health care as a right

What is the cost of not covering people? [as compared to the cost of implementing this reform – cross-cutting issue]

Risk that system change will degrade care for some

Risk of two-tier care system developing

Long-term consequences of government-run system [could include:]

Deterioration of care

Provider flight

Current system is multi-tiered [so concerns about development of two-tiered system may not be relevant]