

HealthFirst Connecticut Authority

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Meeting Summary

Thursday, May 1, 2008

9:00 AM in Room 1C of the LOB

The following members were present: Margaret Flinter, Tom Swan, David Benfer, Mickey Herbert, Michael Critelli, Sal Luciano, Lenny Winkler, Teresa Younger, Brian Grissler, Commissioner Robert Galvin, Franklin Sykes and Fernando Betancourt.

Also present: Barbara Ormond, Randall Bovbjerg, Leo Canty, Paul Lombardo representing Commissioner Thomas R. Sullivan, John O'Connel, David Krause representing Comptroller Nancy Wyman, and Matthew Fair.

The following members were absent: Lieutenant Governor Michael Fedele, Sharon Langer, and Commissioner Michael P. Starkowski

Margaret called the meeting to order at 9:07 AM.

Michael Critelli asked for two changes to the meeting minutes to include a question to John Holahan 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.

A motion to adopt the minutes was made and seconded.

The April 3rd, 2008 Meeting minutes were adopted.

Tom Swan offered an update of the Cost, Cost Containment and Finance Workgroup, at which. Michael Miller gave a presentation on cost containment in the healthcare system. At the next meeting of the Cost, Cost Containment and Finance Workgroup, John Farrel will present on the utilization of data with regard to coordination of care and cost containment.

Margaret Flinter offered an update of the Quality Access and Safety Workgroup. The next meeting will focus on health disparities and workforce development. May 8th is the next meeting.

Tom Swan updated the Authority on the funding that has been reserved for the Authority. A Request for Proposal (RFP) has been developed. Funding has not been released by the Connecticut General Assembly. There is an expectation that a final approval will be given and the RFP will be sent out shortly after the signing of the funding request. This will allow for greater administrative support.

Margaret Flinter expressed her belief that the Authority members agreed that electronic health records, renewed focus on prevention and personal responsibility not just through insurance but through the health department with focus on tobacco and obesity prevention, as well as a focus on the management of chronic disease should be a part of any reform recommended by the Authority.

Tom Swan explained the reading material that had been sent to Authority members. The technical assistance team has been asked to look at reform options within the legislative charge (single payer and universal entitlement to primary care) but also at approaches to reform that build on the existing employer-based system and have been successful in other states. After consideration of these various options, the Authority will decide the subset of options that should be considered in greater depth for possible recommendation to the Legislature in the fall.

Randall Bovbjerg discussed the positive and negative aspects of healthcare reform options as presented in a “side-by-side” comparison that he and Barbara Ormond constructed. For each of the following broad approaches to reform, Randall Bovbjerg presented potentially positive aspects and possible concerns, looking at the effect on consumers, businesses, administration, and insurance plans, as well as the likely extent of crowd-out and adverse selection. (A copy of the “side by side comparison” is available on the HealthFirst Connecticut Authority website.)

Following Randall’s presentation, Tom Swan stated that the Authority members would have an opportunity to comment on each of the options in turn; all comments will be recorded and summarized after the meeting. (A copy of the summary of these comments is available on the HealthFirst Connecticut Authority website.)

He then invited comments on the first option that was presented: “Universal entitlement to primary care or coverage, with insurance purchased for inpatient care only.”

Sharon Langer asked if the Statewide Primary Care Access Authority has developed a definition of “primary care.”

Margaret Flinter reported that “primary care,” has been defined, but “primary care services” has not been defined. Primary care has been defined as continuous, affordable, first contact, and comprehensive healthcare services.

Lenny Winkler expressed concern that there would not be enough primary care providers.

Tom Swan agreed that could be an issue and the Authority would have to determine how to have enough healthcare providers to care for the citizens in Connecticut.

Mickey Herbert explained that in other countries there are true general practitioners. Those practitioners do not have subspecialties. In Connecticut, there are very few general practitioners. Internists tend to practice primary care but have a specialty in a particular area of health. In this system the state would negotiate with primary care providers to reach a payment plan and this may be problematic.

Mike Critelli explained that if the government is involved in setting rates we must consider whether or not the plan will be subject to annual spending caps.

Paul Lombardo asked who would manage the utilization of the non-primary care services.

Margaret Flinter explained that the plan is not complete so we have to determine what that change would actually look like.

Commissioner Galvin explained that there is a problem nationally with getting specialists to see people at community health centers and emergency rooms. People covered by low rate payors are not welcomed by specialists. The second problem is that everyone says they are a primary care physician but not all of those people would fit the definition of “primary care physician.” We also deal with the issue of work hours. Many healthcare workers do not want to work late at night. But we must be able to provide care for people even at hours when primary care workers do not want to work.

Brian Grissler explained there are broad issues that must be discussed including retention of primary care workers in the state. We do not have the resources to keep internists from going into subspecialty work. We need to encourage people to work in primary care. As physicians retire, we may need to hire more than one physician for every physician that retires. We also must think about a greater number of sub-specialists to fill the shortages that we are faced with in our current system. Finally, a model of healthcare that increases primary care must deal with licensing restrictions and guidelines covering non-physician practices such as physician assistants and advanced practice registered nurses.

David Benfer expressed concern that we are approaching a tipping point in the delivery system. This Authority should encourage additional family practice residency programs in the State. By merely increasing primary care, we will not be addressing all of the problems in our healthcare system. Primary care is often just the first step in addressing someone’s sickness. The HealthFirst Authority must take a strong position on the evidence based medicine standards.

Tom Swan asked for comments on the plan entitled: “Regionally organized networks of care (possibly building on / extending Charter Oak)”

Mike Critelli asked why the plan had to be limited to employees.

Tom Swan explained that it would be possible to extend the plan to people who are not employed.

Margaret Flinter explained that elements of this option were modeled after a system in North Carolina; the head of that system recently spoke to the Statewide Primary Care Access Authority.

Brian Grissler asked how we would handle undocumented immigrants in this plan.

Sharon Langer explained that there are some states that do cover undocumented immigrants.

Lenny Winkler explained that there was a Medicaid managed care program created by the state legislature that provided care through community health centers. The plan has some issues but it can be successful. In this scenario we can rely on advance practice registered nurses and physicians' assistants for the purposes of providing care.

Sharon Langer discussed first class and second class medical coverage. When we discuss regional organization of community health centers, we must ask if this is a plan that will cut across income strata. We do not want people to have the perception that people are going into a welfare office when they are seeking medical care.

Paul Lombardo explained that there are certain situations where a person's current lack of insurance becomes an eligibility factor. This could result in a situation where people who have insurance could fall into a category where they would be subsidized in the new program. This could incentivize people to drop their coverage to qualify for another plan. It would be unwise to encourage people to drop their healthcare plan and stay off it for an extended period of time.

Brian Grissler explained that savings can occur if people can avoid going to the emergency room but many of the staff and facilities in the emergency room have fixed funding. This means there is a certain limit to how much can be saved by keeping people out of the emergency room.

Tom Swan asked for comments on the healthcare plan: "Insurance-Choice System."

Mike Critelli asked why we couldn't combine this with a program to cover the non-working insured.

Bovbjerg said that there would need to be an entity to deal with people who are not with an employer.

Brian Grissler addressed the federal healthcare plan and it was a system that contained cost relatively well. That plan may be useful to consider when dealing with this plan.

Mickey Herbert explained his concern that the groups that would be attracted to this plan would be groups that have high healthcare costs associated with them which would drive costs up for others in the pool. This plan may not actually be good for the market.

Teresa Younger expressed her concern with consistency with the benefits that would be offered. We do not want to have erosion of general benefits.

Sal Luciano said it would be important to note that the state employee plan started as a simple plan. Pooling only seems to work as a healthcare policy when there is a stable core of enrollees. A state pool may be exactly what a pooling plan needs to be successful. It may be risky to let individuals self-select healthcare plans.

Michael Critelli differentiated between a rich versus a non-rich plan. The “richness” of a plan is adjusted to encourage good behavior. Our goal must be to encourage people to act in a healthy way.

John O’Connel noted that there is the potential for adverse selection in the plan that is currently being discussed.

Margaret Flinter reminded Authority members that the people who we often think of as representing “adverse risk” are the very people that we want to engage in care, both on moral and clinical grounds but also on financial grounds. High risk individuals are much costlier to the system if their care isn’t well managed.

Tom Swan announced that within the past week, the House of Representatives passed a healthcare plan that mirrors the current discussion topic by a vote of 102 to 43. Tom Swan asked for comments on: “Bolstered Employment-Based system.”

Mickey Herbert announced that the Employee Retirement Income Security Act (ERISA) can be a problem in any employer mandated system. There is a problem with the current system in San Francisco, where there is difficulty dealing with that issue. We have also not discussed the individual mandate which may eliminate the need for an employer mandate.

Tom Swan anticipated that ERISA will be part of any discussion that occurs at the national level.

Mike Critelli observed that the advantage of an employer based system is the ability to change plan designs over time and change them based on market or medical trends.

Fernando Betancourt asked how other countries treat non-citizens.

Bovbjerg explained that it differs depending on the country. He used the example of Britain and Germany and the differences between their healthcare policies.

Mickey Herbert discussed the possibilities that the plan being discussed may not be politically feasible or legal. He also discussed the possibility of adopting a single plan which would generate savings in medical costs made possible through purchasing power. The problem with this plan is the “cartel,” aspects of it. The purchasing power driven in this scenario is only addressing unit prices.

Frank Sykes asked if there was any mechanism that would address the quality of care.

Tom Swan responded that quality of care would be addressed in the “cross-cutting design” and would be part of any reform proposed.

Frank Sykes asked which plan would be the easiest for Connecticut Citizens to pay for.

Tom Swan explained that there is a high likelihood that a large portion of the funds would be public and raised through state revenue. It is difficult to determine which would be the most cost effective without looking further into the design of the plans. A discussion of financing will have to be part of any reform proposed.

Brian Grissler expressed his feeling that a government payment program would do a poor job, as it has in the past, in meeting the cost structure that is in place. Brian Grissler agreed that there are potential savings in the plan in terms of administrative costs. He asked that the plan include specifics about the availability for a private option. Without a private option there may be some Connecticut citizens that live on the borders of the State that move to a private marketplace in another state. He also asked if this plan discourages the decision of businesses considering moving into the State.

Sal Luciano cited New Mexico as a state that looked at single access as a plan that could save money. The plan failed because there was not enough political will to execute the plan. Many of those without healthcare are minorities, women and children. Sal Luciano suggested that morality must be considered when looking at potential healthcare plans.

Mickey Herbert suggested that morality could be viewed through the lens of the likelihood that a particular plan will succeed.

David Benfer commented that the general public believes that healthcare is a right.

Fernando Betancourt addressed the issue of assessing costs for each model of healthcare. We must address the cost of each model and also the cost to the state and the country of lack of coverage.

Mike Critelli asked that the HealthFirst Authority consider health to be a right in the plan that is implemented. If the wrong plan design is used, it is possible to reach care rationing. This plan would not be moral either. We also must consider access to adequate care as a right. We must prioritize health and universal health as goals. Any plan that includes the degradation of health cannot be considered morally justifiable.

Tom Swan suggested that there will be informed and animated discussion over what plan will work best. With the number of experts working on healthcare reform on the Authority, it should be possible to decide on a plan that is right for Connecticut.

Margaret Flinter explained that the electronic whiteboard cannot be used by Authority members to engage in continued discussion between meetings, as it would constitute holding a meeting. She asked members to instead forward comments and thoughts to Randall and Barbara directly.

The meeting adjourned at 10:55 AM.