

HealthFirst Connecticut Authority

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July 16th, 2008 9:00 AM Room 1C of the LOB Meeting Summary

The following members were present: Margaret Flinter, Tom Swan, Fernando Betancourt, Sharon Langer, Sal Luciano, Lenny Winkler, David Parrella, Mickey Herbert, and Franklin Sykes.

Also present were: Lina Lorenzi, Bill Gerrish representing Commissioner Robert Galvin, David Krause representing Comptroller Nancy Wyman, Paul Grady representing Mike Critelli, Randy Bovbjerg, Barbara Ormond, Paul Lombardo representing Commissioner Thomas Sullivan, Lisa Sementilli representing Teresa Younger, Martha Judd representing David Benfer.

The following members were absent: Lt. Governor Michael Fedele, Brian Grissler, Commissioner Michael P. Starkowski, and Kevin Lembo.

Margaret Flinter welcomed members to the meeting and restated the charge to the Authority.

Tom Swan asked for a motion on the minutes.

Mickey Herbert offered one correction to the June meeting minutes regarding the next years deficit.

Lenny Winkler asked for one change to the June Meeting Summary regarding cutbacks in health services at the military base in southeaster Connecticut.

The minutes were passed as amended.

Tom Swan introduced Sharon Langer for the purposes of a presentation.

Sharon Langer offered a presentation on Medicaid. Those who are not covered by Medicaid are non-disabled adults without children; aged, blind, or disabled adults who do not meet income and/or asset requirements; parents and children who do not meet income and/or asset requirements; and undocumented non-citizens (exception: Medicaid for emergency services).

We already use Medicaid waivers and options to expand coverage and reduce costs. In Connecticut we have chosen a mix of options and waivers to expand coverage. With regard to disabled and elderly, we prefer waivers where we can better predict spending (capped enrollment).

We can cover more individuals under Medicaid if we used Medicaid options such as section 1931 income/asset disregards and rehabilitation options or expand home and community based waivers and cover Charter Oak and SAGA adults.

David Parrella agreed that there was no upper income limit but those need to be applied as long as they are in a categorical eligibility group. If they are not in such a group, a waiver must be used. Home and community based waivers have been used extensively.

Barbara Ormond explained that the federal government has put in place restrictions that keep states from transferring the burden of coverage for their citizens to the federal government. It is important to understand that states can't simply give the burden to the federal government without maintenance of effort requirement on the part of the state.

David Parrella agreed with Barbara Ormond that this complicated the issue because the waivers must meet federal tests of cost effectiveness. Policies remain subjected to fiscal scrutiny.

Sal Luciano noted that states spend about 21% of their budgets on Medicaid. Sal Luciano asked what percentage was spent in Connecticut.

David Parrella responded that in Connecticut it was 25%.

Sal Luciano asked if the reason that the percentage in Connecticut was higher was because of the spending cap.

David Parrella responded that he was not sure if that was due to the spending cap.

Tom Swan asked David Parrella if it was possible to have a list of waivers that are currently being considered.

David Parrella offered the list of waivers which includes home and community based waivers for the frail elderly, two home and community based waivers for people with developmental disabilities, a home and community based waiver for people with acquired brain injury, disabled adults who require a person care attendant services, children who would otherwise need a nursing home facility level of care, people with mental illness, and the Department of Social Services is about to apply for a waiver for people with HIV and for adults with autism spectrum illnesses. There is also a different kind of waiver to operate a managed care program.

Sharon Langer explained that the purpose of the federal reduction act was to save the Federal Government state money. It is not about expansions the way the Authority would like it to be. The process has been streamlined the process so that state plan amendments are used to meet approval requirements than the waiver process.

Even if our state can increase enrollment in Medicaid, we face issues of keeping individuals continuously enrolled so they can receive the care they need.

Our HUSKY program has made attempts to learn about what works and what does not in terms of retaining enrollment in the program and to make the program more user-friendly.

Recommended retention strategies for enrollees include automatic enrollment, implementation of “continuous eligibility,” increase income limits further, utilize one updated computer system to determine eligibility and enroll participants, and expand effective outreach strategies. A state of the art computer system may be necessary to continue the program.

Tom Swan noted the turmoil in the HUSKY program during the last few years and asked if that had impacted retention.

Sharon Langer responded that enrollment had been increased and enrollment of parents has dramatically increased. There seems to be a correlation between increasing the income limit for parents in Medicaid and aligning it with children’s income limits. There is no good explanation for the turnover in the program.

Tom Swan replied that it may be that the downturn in the economy that has contributed to the influx of people on the program.

Sharon Langer responded that while this is true it is hard to know where those who have left the program are going.

David Parrella informed the authority that churning is a constant phenomenon in Medicaid because of the nature of the lower income population and the mobility of that population with regard to residence and employment. When there is a recession you will see enrollment in SAGA increase first followed by the HUSKY program.

Tom Swan asked if there had been an analysis of how much of the churning can be attributed to the plan and participation.

David Parrella replied that there had not been an analysis done but the change of the plan is not likely to cause people to drop out of the HUSKY plan.

Sharon Langer added that the report compiled data from January 1st 2006 to December 31st 2007.

Sharon Langer discussed the need to improve provider participation in the HUSKY program. Some providers are hard to locate due to their geographical location. It is possible to increase access in some ways. There may be no single solution to increasing provider access. It may include increasing the amount the providers are paid, raising Medicaid fees to the upper limit that is allowed, rewarding providers for improved access and patient health outcomes, and simplifying procedures for providers such as the credentialing process and electronic health records.

Mickey Herbert asked what it would cost in the State of Connecticut to raise the Medicaid fee schedules to the Medicare level. Private carriers are paying between 120% and 130% of Medicare just to keep a robust panel.

David Parrella replied that 27.9 million dollars took the Medicare system from 42% to 58% of Medicare allowables for physicians. It is expensive to raise the percentages of Medicare allowables.

Margaret Flinter suggested that if the legislature set the rate at a percentage of Medicare, then the process would not need to be re-evaluated yearly.

Paul Grady asked how the providers are able to sustain their work when they are receiving such a low reimbursement rate.

David Parrella responded that the system survives on the good will of providers. Typically what happens is that a provider will accept a number of Medicaid patients so long as the number of Medicaid patients is not so high that it would start eating into the providers expected income.

Tom Swan discussed provider retention and if more preparation work is done and care coordination is provided by medical records, the efficiency of a practice could be increased.

Sharon Langer informed the Authority that Connecticut has not always drawn down full federal DSH allotment because the state must spend state-only dollars to receive federal funds. Some states have been criticized for “creative,” uses of DSH (and non-DSH supplemental) monies to maximize federal funding.

Sharon Langer mentioned that another pot of money that Connecticut has taken advantage of is SCHIP. The reason that 109 million dollars in federal SCHIP funds were not used was because of over-estimated number of eligible HUSKY B children; there are more children in Connecticut eligible for HUSKY A. The state must spend in order to receive.

Paul Grady asked how much of a factor the state spending cap was.

David Parrella explained that Connecticut covers children under SCHIP up to 300% of the federal poverty level which is the one of the best rates in the country. But SCHIP is not a stable environment to look to currently. The federal government has not decided what should be done with the program.

Sal Luciano asked how much of the \$600 million in federal dollars that is left over by the spending cap can be attributed to Medicaid.

Sharon Langer responded that the spending cap prevents the state from using federal dollars. The state needs to use state dollars to get money from the federal government and that is a problem related to the spending cap as well.

Margaret Flinter introduced David Parrella for the purposes of a presentation on HUSKY and the Charter Oak health plans.

David Parrella explained that Charter Oak plan is an attempt to address single adults who are not currently eligible under Medicaid by providing a state subsidized insurance product that they are able to access. This is a product that is like an insurance product and not like Medicaid. It has a premium responsibility, deductibles, co-insurance and co-payments. The goal was to design a program that

individuals could purchase for \$250 a month with a sliding scale of subsidies provided by the state. HUSKY and the Charter Oak plan now has three MCO's (Managed Care Organization.) One contract has already been signed and two are in the process of being signed.

The Charter Oak "kick-off," event was held on June 30th. A call center began taking calls on the same day with over 6,500 calls and nearly 1,700 applications as of July 9th. Applications are available online or over the phone. Pre determination is made from information provided on the quick start application and sent to applicant along with request for additional info needed to make a final determination.

There are deductibles and co-insurance maximums set at five income levels. There is a point at which people need to pay before the plan begins to cover medical costs. Those deductibles are based on income levels.

There are approximately 335,000 people currently enrolled in the HUSKY program.

There will be a HUSKY transition and reminders notices will be sent to non-choosers towards the end of October. The default assignment will be to one of the three MCOs if a client still does not choose within 30 days from reminder notice date.

Primary Care Case Management (PCCM) is a managed care option that will begin on October first. This is a managed care plan where a physician group or group practice agrees to provide certain medical home coordination and in exchange, they receive a per member monthly reimbursement. This plan would be enhanced by an electronic claims record. There is a plan for submittal to Committees of cognizance undergoing internal Department of Social Services review.

There is not a good record of retaining dentists in the system. Early periodic screening diagnosis and treatment measures how many children receive wellness visits that are mandated by federal law. On the medical side, DSS has shown some improvement, but on the dental, only 40% are compliant with the full regiment of visits.

Margaret Flinter asked what the capability of Charter Oak was in terms of the number of people it could care for.

David Parrella responded that 11 million dollars had been appropriated to the plan. If that amount was exceeded, enrollment would be curtailed. The limits on Charter Oak enrollment are driven by finances and the networks that are provided to serve the population.

Sal Luciano asked about the sliding scale that determines deductibles and co-insurance maximums and what would happen if someone exceeded the maximum.

David Parrella responded that the Charter Oak plan would not pay for those people who expand the \$100,000 limit. The state has kept our medically needy income level rather low. It is approximately 60% of poverty. The state has looked at raising the level to the poverty limit. That is a real need with regard to expanding access.

Tom Swan asked about the transition to HUSKY and the relation to Charter Oak. Tom Swan asked how much more we are paying for HUSKY on a per capitated basis than we were a year ago.

David Parrella explained that HUSKY rates are higher but he did not have accurate percentages to provide to the Authority at the time.

Margaret Flinter asked about the status of the HUSKY program as a non-Medicaid program. Because it is not a Medicaid program it does not face the same federal restrictions for coverage of undocumented people. Margaret Flinter asked if there had been any discussion or consideration of allowing that group to participate in the Charter Oak plan.

David Parrella responded that there had been discussion and the current agreement by the Department of Social Services is to allow non-citizens who are permanent residents under cover of law to participate. Those who are undocumented will not be enrolled.

Sharon Langer asked if David Parrella had enough information to discuss who was coming into the program and in which income band the average enrollee was in.

David Parrella responded that he did not have that information but would be able to report that by September.

Sharon Langer asked if regulations would be issued and when that may happen.

David Parrella responded that he expected the regulations could be made by the end of the week.

Mickey Herbert suggested that older people are advantaged by entering the Charter Oak plan but younger people can buy healthcare through private plans more easily. That could mean that those who are in greater need of care are also the ones more likely to buy into the program.

David Parrella responded that Mickey Herbert's concerns are legitimate and that if he is correct it could mean the program will face problems.

Paul Lombardo asked if the premium dollar amounts are fixed.

David Parrella responded that they would be renegotiated next year.

Randall Bovbjerg of The Urban Institute spoke briefly about affordability of coverage. He said that there are two general ways to think about affordability. The first is fairness or need from the perspective of prospective enrollees in health plans. The second is the observed behavior of buyers—that is, households, employers, governments and private charities. Many concerned with fairness to enrollees have cited 5% or 10% of income as a ceiling of affordability for health coverage. It makes sense to have a lower standard apply for the share of income going to premiums than for the premiums plus out-of-pocket costs combined.

The standards for affordability set by Charter Oak and by the Massachusetts Connector provide a different perspective. Charter Oak's premium subsidy scale suggests that it considers the affordable

contribution from single people to be zero below \$15,600 per year, which is 150% of the federal poverty level [FPL]; the state pays the full premium. Above that level, single enrollees must contribute \$75 per month, that is, 900 per year, or 5.77% of \$15,600 in pretax gross income. The maximum earnings for subsidy is \$31,000 per year, or about 300% FPL, at which level individuals must pay \$259 per month themselves. This constitutes \$3,108 per year, which is equivalent to 10.03% of \$31,000 in pretax income.

The Connector has a lower standard of affordability--which means that public subsidy is higher. At 150% of FPL for individuals, Massachusetts requires contributions of only 2% of income. At 300% of FPL, this rises to 4%. Beyond that level of income, there is no public subsidy, but there is still an affordability standard. People of higher incomes for whom insurance coverage is deemed unaffordable are excused from the otherwise applicable state mandate to buy insurance. The affordability standard is 5% of income at 360% of FPL, rising to 6% at 408% and 8% at 505%. Thereafter, any cost of insurance is deemed affordable.

A non-governmental organization in Massachusetts that fosters self-reliance among low-income women calculates that for self-sufficiency a single women in Springfield should budget \$125 per month for health care.

Tom Swan presented Paul Lombardo for the purposes of presenting the Massachusetts connector plan.

Paul Lombardo informed the committee that Massachusetts had low rates of uninsured (6% or 7%). The situation in Massachusetts before the Legislature reformed the healthcare system was very similar to the situation that Connecticut faces now. Before Massachusetts started their connector program, they had relatively low rates of un-insurance (approximately 6% of the population). Massachusetts considered a broad Medicaid program. They had the use of an uncompensated care pool that was renamed the Health Safety Net Trust Fund and they have a highly regulated small group and individual health insurance market.

Shared responsibility was a factor in the Massachusetts plan. This included subsidized care for low income families and a requirement of all individuals 18 years of age and older to have health insurance, required employees with eleven or more employees to provide a fair share contribution, reform of the individual market, and increased Mass Health Reimbursement. There are two parts of the connector program. The Commonwealth care plan deals with the subsidized insurance. Commonwealth Choice is the commercial health market or the non subsidized market where health plans can be purchased through the connector. The benefits have been increased and the premiums have been lowered. They have approximately 17,500 people enrolled in the Commonwealth Choice Program. It is no longer growing as quickly however. As of June 2007, 87% of people were aware of the reform. And in June of 2007 67% were in favor of the change and only 16% percent were opposed to the reform. Employers who were polled, by a small margin, agreed with the requirement that they pay the fair share contribution. Massachusetts has grappled with the public embracing the individual mandate, employer's response to new rules, primary care support of improved access, the possibility that health care inflation could moderate and federal waiver renewal. The issue of affordability is quickly becoming an issue in the Massachusetts plan.

Mickey Herbert made not of an article in the Boston Globe that describes the number of uninsured decreasing. Mickey Herbert emphasized the last point that Paul Lombardo had made which is that it is still too early to know if the Massachusetts plan will be successful there. There is no way to know if the Massachusetts plan will get an eleven-fifteen waiver or if there will be an ERISA challenge.

Sal Luciano asked what the renewal rates were in Massachusetts were.

Paul Lombardo responded that he did not have that information.

Margaret Flinter introduced Paul Grady for the purposes of a presentation.

Paul Grady suggested that a value based healthcare plan design recognizes that not all healthcare is of equal value. Through plan design, provider reimbursement and active plan management, it encourages wise consumption of healthcare dollars. Employers who have implemented a value based approach are realizing savings that are up to 20% lower than what an average employer might be spending. Healthcare can be categorized into several categories: necessary and desirable, discretionary, necessary but avoidable, necessary, but inefficiently delivered, marginally beneficial, and unnecessary and negative. Oregon took steps in this direction by prioritizing care over whether it was necessary and valuable or not.

Many employers cover preventative services at 100%. The reason for this is to prevent more costly care later on. Although the Charter Oak plan focuses on preventable services, there is a short term cost associated with them.

Obstacles to a value-based plan design including the alignment of reimbursement and outcome for employers, and the process by which a determination of what types of care is covered. Of particular concern are those people living in inner city that have complex medical issues.

Randy Bovbjerg suggested that the vision was great but that the implementation would be difficult.

Paul Grady suggested that employers had already had categorized services based on necessity. One example is the unnecessary radiology that is covered by health plans. It is hard to implement a value based plan design because of insurance regulations.

Fernando Betancourt asked what kind of incentives he was referring to under the heading “necessary but avoidable.”

Paul Grady responded that employers encouraged employees to have a health risk assessment by offering them a financial incentive to do so.

Lenny Winkler suggested that tort reform plays a part in the value based plan design.

Paul Grady responded that it would be of real value if there was an organization of experts who put care into categories and promulgated evidence based medicine. If a provider followed evidence based guidelines, which should be a good defense if they were to be sued for malpractice. Currently there is no such organization exists.

David Parrella informed the committee that there is no way to avoid litigation.

Sharon Langer asked if this had been developed to the point that there were evaluations of the plan.

Paul Grady responded that there are studies that evaluate value-based plan design. Value based plan design is a system that allows procedures that are not consistent with medical evidence, but that procedure would be more expensive.

Lisa Semitelli agreed that information on evaluations of the value-based approach was necessary.

Paul Grady responded that a health plan is just one element of the discussion.

Tom Swan discussed the next steps the HealthFirst Authority intended to take and offered an update of the progress of the Authority to date. The next meeting will be September 11th at 9:00 AM. The meeting will probably last three hours.