HealthFirst Connecticut Authority

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Meeting Summary
October 23, 2008, 9:00AM Room 1D of the LOB

Those Present Were: Tom Swan, Margaret Flinter, Sal Luciano, Kevin Lembo, Mike Critelli, Lieutenant Governor Mike Fedele, Lenny Winkler, Teresa Younger, Mickey Herbert, Commissioner Thomas Sullivan, David Benfer, and Sharon Langer.

Also Present: Pam Koprowski representing Brian Grissler, and David Krause representing Comptroller Nancy Wyman.

Those Absent Were: Commissioner J. Robert Galvin, Commissioner Michael P. Starkowski, Fernando Betancourt, and Franklin Sykes.

Tom Swan asked for a motion to pass the September 11th meeting summary.

Lieutenant Governor Michael Fedele asked that the person who had been present at previous HealthFirst Authority meetings, who had represented him there, be added to the meeting summaries.

Tom Swan clarified that if no one had sat at the table or checked in with the clerk to notify the Authority that they were present, it would not be possible to amend the previous meeting summaries.

Margaret Flinter clarified that while the previous meeting minutes could not be edited without a vote, the meeting summary of the October 23rd, 2008 HealthFirst Meeting summary would reflect the Lieutenant Governor's request.

A motion was made and seconded

Margaret Flinter offered an update of the recent work of the Cost, Cost Containment and Finance Workgroup. The recent meeting focused on the issue of liability and malpractice and how that affects care in Connecticut. It is within the scope of the Authority to make recommendations that deal with patient safety, and the prevention of mistakes that lead to law suits.

Margaret Flinter offered an overview of the public hearings that were held over the last several weeks across the State. Connecticut citizens were very appreciative of the opportunity to voice their concerns with the status of healthcare in Connecticut. Recordings of the meetings as well as testimony that had been submitted are all available as part of the public record of the hearings. Margaret discussed some of the stories that were shared at the hearings by members of the public. The common theme that all

testifiers seemed to agree on was that all people in Connecticut should have health coverage, people believe they should pay their fair share and there is a level of shared responsibility, Medicaid ought to be as good as any other type of insurance, people should not be forced to travel long distances for care, and losing your job should not mean losing your insurance, oral and mental health need to be part of the solution that the HealthFirst Authority arrives at, and there was a sense of urgency when it came to healthcare reform in Connecticut.

Tom Swan discussed some of the healthcare reforms that recently took place in Kansas. Tom Swan introduced Randy Bovbjerg for the purpose of a presentation on the Kansas healthcare reforms.

Randy Bovbjerg discussed the program in Kansas. In Kansas, one striking feature of the plan is the level of coordination. The long term goal of the group was to create better health for the citizens of Kansas. The group that coordinated the healthcare reform was created in 2005. The group reported to the Governor but was revised and began reporting to the Legislature. The Governor and Legislature asked for a report in 2007. The plan was debated and the success was limited. They decided to endorse a plan that promoted personal responsibility, paying for prevention and health promotion through medical homes, and providing and protecting affordable health insurance. Kansas hired a firm to do actuarial analysis. A series of public hearings were held across Kansas, and subsidiary task forces were established to help study healthcare reform in Kansas. Kansas was data driven in their work. The Kansas Legislature wanted reports in the following categories: the medical care system, delivery changes, public health efforts, population based efforts, and expanding affordable insurance coverage through particular initiatives. The general pattern in Kansas showed that if a reform was suggested, and that reform required funding, it was unlikely to pass. Controversial suggestions were left to be studied further. Kansas built relationships with groups to advocate for change, a working board was created composed of community members and agency reps. Kansas decided that good health should be the goal, and this included a change in mentality. Coverage should be discussed as a means. Kansas used and committed themselves to evidence based policy making, and took data collection and analysis quite seriously. The centralization of state purchasing programs is a way to harmonize signals. The merger of plans has occurred. The goals of Connecticut are congruent with the goals that Kansas created.

Tom Swan reported that municipalities were able to buy into the state employee plan, and small businesses were not.

Mike Critelli discussed the possibility and likelihood that health planning functions could be adapted to Connecticut as well as the use of a public/private body for standards and health promotion. There is a distinction between oversight and coordination and pooling. Mike Critelli asked Randy Bovbjerg how the board in Kansas was constructed.

Sal Luciano agreed that the approach was good. Sal Luciano asked a question about page 20 where the report asserts that Medicaid and SCHIP consumers went through a utilization of value based purchasing strategies. He asked for more information on that particular topic.

Mickey Herbert asked about the connector and asked if that was considered but rejected.

Randy Bovbjerg responded that neither universal health plan nor a broad based comprehensive one had been accepted.

Mickey Herbert suggested that the Authority was looking at putting state purchasing functions within one agency, but nothing effectively beyond that.

Randy Bovbjerg agreed that to this particular point, that was the case.

Mike Critelli asked what percentage of uninsured there were in Kansas.

Randy Bovbjerg responded that the number is probably slightly higher than it is in Connecticut, but the actually numbers were not available at the time.

Lenny Winker asked if Kansas had a problem with the number of providers operating in the state.

Randy Bovbjerg responded that he thought that was a problem in the state.

Tom Swan reported that there are 90 non-state group employers participating with 5,157 contracts, the majority are schools and municipalities.

David Krause asked for details on the pre-existing authority during the 2005 legislation that handled the state's Medicaid population, and additional state programs were added.

Randy Bovberg confirmed that was the case, to run a Medicaid program there must be a single state agency that deals with it.

Tom Swan added that the Department of Social Services (DSS) continues to play a part in administering the program.

Mike Critelli asked if Kansas used a third party data collection resource.

Randy Bovbjerg responded that the major effort is to collect all types of standardized data sets. Data from other sources is probably available but Randy Bovbjerg was not aware of it.

Tom Swan expressed confidence that the State Comptroller used a third party source for data collection and there is no connection between that and the data that may be collected by DSS. Tom Swan asked if that information is ever shared with policy makers.

David Krause responded that he did not think so but would confirm with him when he had an answer.

Sharon Langer added that Medicaid data is stored in a warehouse and Connecticut Voices for Children has access to that data. Therefore it would seem possible to gain access to the data Mike Critelli was referring to.

Mike Critelli clarified that a situation had occurred at Pitney Bowes the generated a high number of chronic disease costs. That caused the co-pays to increase on the plans as a way of reducing costs. In doing so, Pitney Bowes found out that Pharmaceuticals spend far less than what should have been. Claims data and pharmaceutical data is important and also other specialists' data in the behavioral health

arena. If the Authority had to do that type of data collection, would the tools be available today or would they need to be created?

Sharon Langer responded that DSS has an enormous amount of data in their data warehouse; enough data to determine, for example, what the utilization rate is for conditions such as asthma. However, the department may not have the resources available to do the types of analysis that Mike Critelli is interested in.

Margaret Flinter suggested that Conecticut does not have the ability to do the type of data collection the Authority is discussing. The ability of Connecticut to do predictive modeling is not available, even though the technology is.

Lieutenant Governor Mike Fedele confirmed Margaret Flinter's statement, and that is an issue that had been discussed by the eHealth Committee. There is no repository of data that deals with Medicare and Medicaid data from a public or private provider perspective.

Randy Bovbjerg asked for clarification that issues such as the process of using an outside vender, the parts of the claims database that could be integrated, and benefits design, were issues that were of interest.

Mike Critelli explained that Medstat collects information at a population level. Pitney Bowes is self-insured with an administrative services operator. There are multiple insurance companies that are contracted with. There are, at a minimum, four sources of data. Mike Critelli asked if Kansas was trying to take DSS and Insurance and collect data from those places.

Randy Bovbjerg responded that was what they were starting to do, and more information would be available soon.

David Benfer offered his concern that there was no central repository of historical data. There must also be ways to integrate epidemiological data, data about demographic changes, and data that includes technological advances.

Commissioner Thomas Sullivan suggested that one challenge that the Authority would face are problems with the ERISA plan. We do not even know who the third party administrators are. They are not registered with the Department of Insurance.

Margaret Flinter agreed that would be true from the claims data perspective but there is also the ability to submit data at the point of delivery level.

Lenny Winkler suggested that there is probably more data that we realize. The data is probably fragmented and to have a handle on the issue there must be a central repository.

Tom Swan asked about conflicts between the public's right to know and proprietary information from an insurer's perspective. Tom asked for an explanation of where some of those tensions come from.

Mickey Herbert responded that claims data enables ConnectiCare to follow diseases and administer disease management programs. The limitation is that it is not electronic medical records, and some claims are not entered into the ConnectiCare database. Mickey Herbert informed the Authority that he did not have information about the public enrollment.

Sharon Langer reminded the Authority that there was recent legislation that created a Connecticut health information network. That network may be useful.

Beverley Henry informed the Authority that it is called CHIN and it was created through the University of Connecticut.

Tanya Court suggested that there may need to be legislation passed to require insurance companies to provide claims data. Race and ethnicity data needs to be available to identify potential disparities as well.

Paul Harris made the point that many clients would voluntarily submit their data. It may make sense to gather data without a great deal of trouble or legal work.

Commissioner Thomas Sullivan reminded the Authority that there are other states that have done comprehensive data aggregation data collection. We need to look at what those states have already done.

Sal Luciano pointed informed the Authority that the states that spend the most on Medicare and Medicaid also tend to have the worst outcomes and it is worthwhile to find out why that is.

Sharon Langer made the point that Medicare and Medicaid, by definition, are dealing with the sickest people in the state.

Mike Critelli suggested a two stage program. Connecticut would look at where we already have state administered programs and take a look at the different dimensions of planning. Connecticut would not always need 100% of the data, and we need to figure out in which cases we simply need a large sample size of data.

Commissioner Thomas Sullivan asked what the goal of the data collection would be. Would it be to retrieve full samples so that you can make ongoing policy decisions or is it to guide the work from the HealthFirst Authority.

Tom Swan discussed the status of the financial modeling assistance. It appears that there will be agreement that the Authority may use the aforementioned data from MIT. Tom announced that the one rule in further discussion is that if a proposal deviates away from reaching the Institute Of Medicine (IOM) principals, it will be ruled out of order. The first thing we have discussed is the creation of a quasi-public trust.

Mike Critelli discussed the challenges of pooling.

Tom Swan suggested that there would be a high likelihood of federal reforms. Those potential reforms are not included in the document. Tom asked for further comments on Roman Numeral I of the modeling outline.

Mickey Herbert agreed with Mike Critelli that the first four items are acceptable but there is a real question dealing with what the trust would do beyond data collection. The issues of the connector and who else is involved in the health plan remain. Mickey Herbert suggested that the quasi public trust should be limited to data collection, health planning and establishing standards. Mickey Herbert asked that if there would be a vote on a proposal that included an employer mandate and an individual mandate, and/or a substantial financial obligation from the state, he would need more information about the proposal.

Lieutenant Governor Mike Fedele asked if the chairs believed that the charter of the committee is to consider cost and financing of a new healthcare system.

Margaret Flinter responded that cost was part of the consideration outlined in the legislation.

Lieutenant Governor Mike Fedele asked if a financial modeling would be done of the plan, but that cost was not a current consideration.

Margaret Flinter responded that the Authority has been looking at cost and value during their deliberations.

Tom Swan added that the Authority intended to attain the broadest agreement possible. How the new healthcare system would be financed is part of the charge, but the current state deficit is not. Whatever the Authority decides on will be phased on over several years. The fact that the state has a deficit should not change the Authority's mission.

Lieutenant Governor Mike Fedele asked if there would be an attempt to finance the proposed system.

David Benfer agreed that the document that the Authority intended to create is designed for years down the road. One level of decision making that must be done is to determine how much coverage particular plans offer. Another issue is the determination of the effectiveness of certain medical efforts.

Tom Swan felt that a transparent process was necessary so that people could have faith in the decision making process that occurred in Connecticut, regarding their own healthcare.

Margaret Flinter introduced section two of the working draft, and explained that they were a collection of ideas born through long discussions in the Workgroups.

Sal Luciano expressed concerns with end of life situations. A large amount of money is spent on end of life care. There is no problem with prolonging life but there are times where we spend massive amounts on prolonging death. That could be considered a quality improvement and cost containment.

Sharon Langer discussed the difficulties of retention of coverage in public programs.

Mike Critelli asked for a description of pay for performance.

Margaret Flinter responded that based on discussions, the term referred to rewarding better health outcomes with increased reimbursement. Connecticut should have a program by which people are positively incented to improve their patients' outcomes.

Martha Judd expressed her feeling that it was unclear if the trust would take over certain responsibilities.

Tom Swan responded that the Authority had not gotten down to that level of specificity.

Lenny Winkler asked about expanding Connecticut's pool of providers.

Margaret Flinter responded that while that is not expressed specifically in the outline, there is room in the plan for expanding Connecticut's providers.

Margaret Flinter agreed that was a good point.

Mickey Herbert asked if the Authority would take over the responsibilities and functions of OHCA, DPH, the Comptroller's oversight of the State plan, DSS, and the Office of the Healthcare Advocate.

Tom Swan suggested that unless the Authority had a specific suggestion, that decision could be made by the Legislature.

Mickey Herbert felt it might be hard to model the program without making a decision on the state programs. An additional concern is the ability of the Authority to determine the price of a health plan through minimum medical loss ratios.

Tom Swan responded that the issue Mickey Herbert was discussing was not necessarily going to appear in the final report, and it was something that had been debated previously by the Legislature and probably would continue to be debated.

Mickey Herbert announced that he would not support a minimum medical loss ratio and would like it to be taken out of the framework for discussion.

Tom Swan suggested that there are others that support it and the purpose of the discussion is to flag concerns that members have.

Lieutenant Governor Mike Fedele asked for more information regarding minimum medical loss ratio's.

Tom Swan explained pooling of risk, which is the health partnership and the potential for businesses to buy into an insurance pool. Self-insurance by large entities could save the state significant amounts of money. Perhaps the option should be available even if it is not utilized. Minimum medical loss ratios is a plan that requires a certain percentage of every health care dollar collected by a health care plan to be spent on healthcare.

Mickey Herbert responded that the fundamental problem with medical loss ratios is that if a health plan does a good job of reducing medical expenses; its medical loss ratio is going to go up. And if it goes beyond a certain level the state would have to take a certain amount of money and the plan would ultimately fail. Mickey Herbert asked if the Authority was endorsing such a plan.

Tom Swan responded that it was not.

Mike Critelli discussed general administrative overhead and disease management, care coordination, and technology investments are part of administration. There is a risk of using percentages and it demands that there be a judgment made on how money is spent. In an insurance environment, who is the person that answers the questions that people have and what level of support is there. The support system will have a good deal to do with the cost of the administration of the program. Things like service level standards need to be defined if we could ever move towards a minimum medical loss ratio plan.

Mike Critelli discussed the standards of the support services.

Sal Luciano suggested that money spent on healthcare not be considered a "loss."

Lieutenant Governor Mike Fedele asked if there was a level of detail that someone on the Authority could look to when trying to answer some of the questions that have been asked at the meeting today. When modeling a cost structure, there are detailed questions that must be answered.

Tom Swan responded that the details are in the minutes of other meetings that the Authorities and Workgroups have held. It is too early for the Authority to come up with that level of detail at this time and additional details will be determined by Legislative leaders and the Trust itself.

Lieutenant Governor Mike Fedele asked for clarification that the Authority would pass the suggestions on to the Legislature, to let the Legislature work out the details of the plan.

Tom Swan confirmed that not all of the details needed to be worked out by the Authority.

Margaret Flinter agreed that it did not make sense to model a plan that is beyond the scope and control of the Authority.

Tom Swan announced that even through there was not complete agreement on the partnership pool, it would be modeled because it has significant support in the Legislature.

Mike Critelli discussed the state employees plan. The two issues with that plan are the percentage reimbursements that were bargained between the state and the unions, and the issues of allocation of cost and specific plan designs. Mike Critelli asked if there was a place that explains to a state employee plan participant what the plan offers them.

Sal Luciano explained that there are point of entry plans, points of service plans, and they are for single coverage, subscriber plus one and family coverage. There is a formula that changes every year that determines the copay. The goal was to push employees towards the cheapest plan.

Tom Swan informed the Authority that the state employee contracts could be out to bid as early as 2010. If the partnership moved forward, it would allow for time for people to buy in and it would allow for transparency of design. It could also address some of the Governor's concerns with the bill.

Mike Critelli asked about a provision that precludes coverage of experimental treatments. A body determines what experimental treatments are. Mike Critelli asked if that would be in the individual insurance plans that the employees buy into or if there is an overarching philosophy that all insurance plans adhere to.

Sal Luciano explained that there was a pre-approval.

Kevin Lembo explained the differences between some of the plans.

Sharon Langer asked if DSS had offered a list of waiver provisions.

Margaret Flinter responded that she had no such document.

Sharon Langer reminded the Authority that most Medicaid dollars are spent on the elderly and people with severe disabilities. The process of getting them the most cost effective care is important.

Lenny Winkler reminded the Authority that she had discussed an education program.

Margaret Flinter responded that was important and probably deserved a bigger role in the proposed framework.

Tom Swan suggested that there would need to be some compromises made and financing the program would certainly be difficult.

Sal Luciano announced that Massachusetts got hundreds of millions to help finance their new healthcare program. Sal Luciano announced that he was not sure how he would vote for the plan if he had to vote on it now. If the plan does not provide quality healthcare, he would not be able to vote for it.

Mickey Herbert commented that the notion of a quasi public trust is much like a large Christmas tree adorned with bad ornaments. There is a risk that we can go too far with a bad program and then we will have nothing to show for a lot of hard work. Two of the problems are the notion that employers would need to pay into the program, and the enforceable individual mandates that many people could find offensive.

Tom Swan shared some of Mickey Herbert's concerns but admitted that the charge of the Authority was to create a universal healthcare system and that there must be certain changes made to accomplish that.

Margaret Flinter noted that those who testified at the public hearings did not voice a concern with the personal mandate.

Kevin Lembo informed the authority that if certain protections and provisions were in place that it could be possible to agree on a personal mandate. The language behind the ultimate bill would need to be very

specific because the intent of the legislation would be to create quality healthcare that is cost effective and if the legislation is unclear, vague portions of the bill would be left to individuals such as commissioners to take a stance on. That could decrease the effectiveness of the legislation. Finally, an area of potential concern is the ability of the Legislature to dissolve the board if they become unable to fulfill their charge.

Mike Critelli suggested that the employer or individual mandates would be lesser or greater burdens based on the cost of the plans that they are asked to support. There must be a study of the insurance mandates that we have accumulated legislatively over the last few decades, and whether or not they make sense. Another discussion that needs to take place is the benefit of a "sin-tax," and the potential health and budgetary benefits of placing higher taxes on unhealthy products such as cigarettes and alcohol. The final point Mike Critelli made was the potential savings that could be made by preventing accidents. One way to do this is speeding cameras. This would reduce healthcare costs by reducing accidents and at the same time reduce congestion.

Sharon Langer suggested that with lower income folks, they will not make the payments and as a result they will be fined and will accumulate criminal penalties instead. The design should protect people from that cost sharing. Sharon Langer suggested that proposals that made those changes would allow her to support a final proposal. Research shows that you need to reach a certain level above the FPL before people will begin paying into a health insurance plan.

Randy Bovbjerg suggested it would be hard to see how the IOM principals could be complied with without automatic enrollment or a mandate.

Margaret Flinter reminded the Authority that many Connecticut citizens that testified at the public hearings reported that after they had spent money on premiums they were not able to afford care.

Tom Swan announced that the next meeting would be scheduled for November 20th. By that time, there should be more information available to the Authority from Jonathan Greuber at MIT.

Lieutenant Governor Mike Fedele suggested that in light of the financial crisis it may make sense to ask for more time to make a proposal.

Tom Swan responded that the Authority would at least offer the Legislature a status report, and would ask for the rest of the year to finish the Authority's work.

Lieutenant Governor Mike Fedele expressed his feeling that it was far more important to have a final product that could help alleviate the uninsured in Connecticut and had as much agreement as possible among Authority members. Meeting the deadline as proposed in the legislation should not get in the way of a good final report.

The meeting adjourned at 11:50 AM.