

DRAFT FOR DISCUSSION ONLY

Updated Outline for HealthFirst Connecticut Authority

- Executive Summary
 - Goal Healthy Connecticut
 - Need – Universal access and transformation of health care system
- Preface
 - History of the Authority, members, meetings, process, documentation
- Report
 - Introduction
 - Approach to the problem, setting up the argument that expansion of coverage and system transformation need to go hand in hand and will benefit all once the transformation is completed
 - Overview of Insurance Coverage in Connecticut: to set up the building blocks that will be improved/enhanced/expanded to reach/approach universal coverage. Each section will present the facts about the coverage then an overview of the challenges associated with the coverage
 - Employer-sponsored Insurance
 - Public Healthcare Programs
 - Uninsured
 - Underinsured
 - Overview of Healthcare System Issues in Connecticut: (and elsewhere)
 - Structure and financing
 - Money flow
 - Regulatory
 - Underpayment by public providers (with associated poor participation by providers in public programs and cost shifting)
 - Inefficiencies
 - Slow uptake of HIT
 - Lack of data and transparency, with resulting lack of accountability
 - Lack of focus on chronic disease prevention, treatment, management
 - Lack of coordination among providers
 - Importance of mental and dental
 - Burdensome bureaucracy
 - Inequities
 - Racial/ethnic Disparities
 - By disease status (because of exclusions in coverage and in benefits)
 - Importance of mental and dental

- Result is costs are higher than need be, unsustainable, and often represent poor value for the money
- - Statement of Vision – Healthy Connecticut
- Underlying principles of Coverage
 - IOM
 - Value based
 - Universal
 - Affordable
- Underlying principles of Care
 - Access – patient centered, culturally competent, coordinated, encourages health and integrated, adequate staffing
 - Quality and efficient – evidenced based, less bureaucracy , safety, HIT

Recommendations

- Strategy to achieve vision of ensuring access to quality care for all residents of Ct. universal coverage using building block approach
- Coverage expansion strategies
 - Access to essentially “group” coverage under Medicaid for individuals with less than 300% poverty (maximum federal allowable for match)
 - Submit federal waiver requests to convert SAGA and Charter Oak to Medicaid programs, gain federal match, and access additional \$100m of disproportionate share hospital (DSH) funds available to Ct.
 - Add a new “Charter Oak B” or other publicly sponsored option with no pre-existing exclusion for individuals with incomes over 300% of the FPL, with premiums and co pays as in Charter Oak but limit out of pocket expense to a specified percentage of income on a sliding scale up to 450% of FPL
 - Focus on value based plan design including at least basic dental coverage
 - Add a stepped (sliding scale) premium for HUSKY B children between the current \$50./mo for those < 300%FPL and the \$200/mo per child for those over 300%
- Allow businesses the option of joining state employees pool at next opportunity. Over time, pool risk of MEHIP, State Employees, and eventually Medicaid.
- Institute Point Of Service enrollment in all public programs.
- Consider replacing provisions for signing up for insurance with provisions for opting out of coverage
- To be discussed: individual mandate or no individual mandate or defer decision on individual mandates?
- To be discussed: employer health care tax if not offering any health insurance/health care coverage to employees, at defined percentage, to fund expansions

- Care transformation strategies
- Strategy to incent/support achievement of “medical home” by practices, as defined by NCQA
- Expansion of PCCM
- Strategy to speed up implementation of electronic medical records and e-prescribing
- Requirement for use of electronic prescribing by specific date
- Strategy to encourage use of evidence-based medicine
- Pilots to assess best approaches to chronic care coordination
- Strategy for emphasizing prevention, wellness, workplace support
- Recommendation for essential dental services inclusion
- Ensuring behavioral health parity

- System redesign strategies
- Increase provider reimbursement rates under public programs to a specified percentage (90-100%) of Medicare rates
- Develop automatic enrollment of providers into public programs at time of licensure with an opt-out provision.
- Establish and implement safety standards: metrics, goals, reporting, monitoring
- Evaluate all state spending on health care for value and implement changes where indicated
- Prioritize training, recruitment, and retention of primary care providers, support full utilization of all primary care providers in state
- Increase transparency and data collection to provide basis for assessing value and accountability

Oversight entity to drive change: the Ct Health Trust

- Rationale for CHT – the state of Connecticut, as the largest purchaser of health care in the state, needs to be a smarter purchaser of health care, should use its market clout to drive structural changes that will make health care better and more affordable. The CHT represents the most efficient way to capture current investments and expertise in data collection, analysis and reporting to drive smart investments, develop future models, and implement value-based plan design across multiple insurance coverages and delivery systems.

- Recommended Structure:
- Quasi Public
- Five person Board appointed by Governor and legislative leaders with strong conflict of interest protections
- Ex-Officio include OPM Secretary, Comptroller, DSS Commissioner, DPH Commissioner, OHCA Commissioner, Health Care Advocate, and CHEFA, which will all have reporting duties to the Trust
- Recognition of current budget constraints for new funding and exploration of possible consolidation of existing functions
- Authority to establish work groups for explicit functions such as expert panel to review evidence based guidelines

Charge to CHT:

- Oversee and coordinate state purchase of health care including the ability to pool risk, negotiate discounts, and engage in cost containment strategies. This oversight will include all programs in which the state has a financial stake.
- Implementation of national health care reforms
- Establishment of goals and evaluation of progress in areas where there is likely to be an effect on health for the residents of Connecticut.
- Ensure transparency through coordinated data collection and analysis.
- Advance transformative changes to health care system including, but not limited to, adoption of medical homes, use of evidenced based medicine, and use of value based health design.
- Ensure everyone has access to quality affordable health care by 2012.
- Monitor and initiate strategies pertaining to racial and gender disparities, workforce development, and patient safety.

Financing

- Maximize federal funding.
- Increase tobacco and alcohol taxes
- Consider taxing unhealthy food (needs to be balanced with efforts to ensure access to healthy foods in underserved communities)
- Assess employer fair share
- Consider individual mandate versus optional enrollment. If mandate, what type of market reforms needed.
- Investigate strategies used by other states for financing coverage, including MA and OR

Cost Containment

- Many of transformative changes will save money over time, but will cost up front.
- Adoption of evidenced based medicine guidelines can eliminate need for prior authorization in Trust based programs and to discourage some lawsuits
- Trust should adopt standardized claims process for public programs that will lessen bureaucratic overhead for providers
- Minimum medical loss ratio
- Greater transparency including disclosure of any potential conflict of interests
- Evidence-based review of consumer protection/mandates
- Limits on pharmaceutical costs including companies gifts to provider, support for continuing medical education, increased use of generics, and counter detailing.