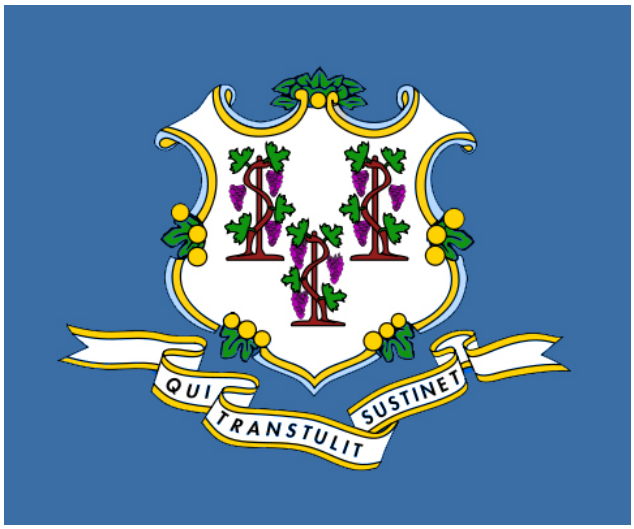

HEALTHFIRST CONNECTICUT AUTHORITY

REPORT TO LEGISLATURE

MARCH 11TH, 2009

SUBMITTED BY

MARGARET FLINTER AND TOM SWAN

CO-CHAIRS

March 11, 2009

An open letter to the people of Connecticut regarding the work and recommendations of the HealthFirst Ct. Authority:

Over the past eighteen months, we have been honored to serve as co-chairs of the HealthFirst Ct. Authority. The Authority is a group of citizens appointed by the Legislature in 2007 to study and recommend ways to guarantee that all Connecticut residents have access to health insurance coverage and to safe, quality, health care.

It was a tall order when we were appointed, and the profound changes in our state and country over the past year have only made it more so. We, along with our fellow members of the Authority, bring our own personal and professional experiences, beliefs, and values to the work. We represent many different walks of life, but when we accepted our appointments to the Authority, we indicated our commitment to the Institute of Medicine's principles for coverage—continuous, equitable, affordable and sustainable—and its principles for healthcare—safe, timely, patient centered, of high quality, and effective.

It would be easy for any one of us on the Authority to put forth on our own preference for how to fix our healthcare care system and say "now just do it!" But that's not the way it works. We have had to listen, learn, and sometimes change our personal views in the interest of actually creating change for the better. We have found common ground in many areas, and not surprisingly, we have significant areas of difference on the best path forward for our state and all who live here.

On December 17th, we submitted a final draft report to the Legislature, and also made it publicly available. Everything we have done as an Authority has been open and transparent—every meeting, every document, every speaker or presentation has been recorded and is available for review. On December 17th we brought together our many workgroup members, legislators, and other interested people to discuss the Report. Based on that discussion, we considered additions and changes and worked to broaden our areas of consensus and minimize our areas of differences. We did this in the context of a change in federal administrations, profound changes in the economy, and evolving thought in the healthcare, business, insurance, and consumer communities both locally and nationally.

The Authority met again on February 24 for the purpose of a final review and discussion, to vote on approval of this Report, and to officially forward it on to the Legislature. It is a true and proper reflection of the democratic process that the members of the Authority retain some strong differences on the best path forward. We are proud that the Authority voted by an 8-2 majority to approve the Report. In keeping with our process, we allowed an additional week for members to submit supplemental comments and those are now included as part of the final document.

It now becomes our charge as citizens to advocate for the changes we believe move the State of Connecticut forward in the goal of universal access to care that is safe and high quality, cost effective, equitable and just. No doubt about it, substantial changes will be made. We all must take seriously our responsibility to monitor and evaluate the outcome and impact of those changes, and strive to make the necessary course corrections and improvements as more data becomes available.

We want to thank you for *your* contribution to the process. Hundreds of you came to one of our nine public hearings held across the state in the Fall of 2008. You provided testimony that was eloquent, insightful, and helpful. You spoke with incredible Yankee common sense, sometimes through an interpreter, and sometimes through your tears. You made it clear that you want a fair deal and are ready to pay your share. We also want to thank all of the people who worked with us—on a completely volunteer basis—contributing their incredible expertise in complicated areas. None of them received so much as gas money for their time and trouble. They truly deserve our appreciation.

This Report lays out the issues of both coverage and care, and recommends ways to achieve our vision for healthy people and healthy communities in Ct. The 2009 General Assembly, along with our federal government, is considering many options for health care reform. There will be a lot of further discussion and this is good. If solving healthcare was easy, someone would have done it long before we came along.

Thank you again for the great privilege of allowing us to lead this effort.

Tom Swan
Co-Chair

Margaret Flinter
Co-Chair

Executive Summary

The HealthFirst Connecticut Authority was charged with studying and recommending ways to guarantee access to health care for all residents of Connecticut, with consideration for the Institute of Medicine principles for health coverage and healthcare. Throughout its work, the Authority has reviewed evidence that consistently suggests that current expenditure trends are not sustainable into the future, and that healthcare is not as equitable, as effective, or as accessible as it should be. The residents of Connecticut are not getting as good a return on investment in healthcare that they could, and some residents are suffering greatly under the current status quo. Connecticut can do better.

Process

The co-chairs convened the initial meeting of the Authority in October, 2007. The Authority held 27 meetings between October 2007 and December 2008, all at the Legislative Office Building. Of these, 14 were meetings of the full Authority, and 13 were meetings of its two major workgroups. These workgroups were known as the Quality, Access, and Safety workgroup, and the Cost, Cost Containment and Finance workgroup. Each group brought together more than 50 people with an extraordinary depth and breadth of knowledge and experience in the areas of most concern and interest to the Authority.

During this time the Authority secured the expert testimony of individuals from around Connecticut and across the country; reviewed data, reports, articles, and expert panel proceedings on a wide array of pertinent topics; and hosted a series of nine public forums in cities and towns throughout the state.

Vision

The Health First Connecticut Authority started with a vision to protect, improve, and maintain the health of all people of Connecticut. Realizing this vision calls for both short-term and long-term focus on

- Ensuring that every resident has access to group-based public or private health and dental coverage that is affordable for the individual, family and state of Connecticut.
- Ensuring that both health insurance coverage and healthcare meet the IOM principles: timely, safe, patient-centered, equitable, sustainable and effective
- Ensuring access to a medical/healthcare/dental home for every Connecticut resident
- Making prevention a priority
- Promoting personal responsibility and action for healthy behaviors

The principles of coverage underlying this vision are that coverage should be available and affordable and that the benefit structure should be evidence-based. The Authority considered a wide range of alternatives for coverage expansion, including a single payer system, a bolstered employment-based system, insurance choice/pooling, regionally organized networks of care, universal entitlement to primary care with insurance coverage for inpatient care only, and an individual mandate for the purchase of insurance. In addition, the Authority considered how to transform the delivery system to improve access and quality for better value and to contain costs so that universal coverage is affordable for society.

The recommendations propose a broad strategy rather than a detailed plan. The fundamental principle underlying the Authority's recommendations for universal coverage and effective care is that it be value-based—value in the health and wellness of both individuals and communities, value in the return on the financial investment by taxpayers and other payers, and value in the realization of a just and equitable approach to health care for all. Accomplishing this goal requires transformation of the way care is organized and delivered, in how and what care is paid for, in the collection and analysis of health information and data, and in the measurement and evaluation of the progress made. All groups, whatever their insurance status, face the same issues: cost, cost containment, and financing of healthcare; and quality, access, and safety. The Authority strongly believes that expanding coverage and transforming care must go hand in hand

Recommendations on Coverage Expansions

- Connecticut's approach to universal coverage will build upon the current employer-sponsored healthcare system, allowing those who currently have health coverage that is acceptable and affordable to them to continue with it, and encouraging employers to maintain their current health benefit contributions.
- Every state resident will have access to health and dental coverage via a health insurance pool with group protections, whether private or public.
- Every resident with an income below 300% of the federal poverty level who cannot access employer-sponsored insurance will have access to a public (Medicaid or SCHIP) product. Premiums, deductibles, and co-pays will be consistent with generally accepted affordability indices.
- All insurance coverage paid for in full or in part by the State of Connecticut. will incorporate value-based design elements that emphasize prevention, early detection, and effective disease management.
- Connecticut will maximize federal reimbursement within all public health insurance programs. Remaining costs will be distributed fairly among employers, individuals, and the state.
- Connecticut will avoid "crowding out" of employer-sponsored insurance even as it expands public insurance coverage. It will allow flexibility to subsidize low income workers who have access to employer-sponsored insurance but cannot afford the premiums
- Connecticut's approach recognizes the need to engage the full healthcare community in the care of publicly-insured patients as well as privately-insured patients through addressing inadequacies in the public program fee schedules for children and adults.
- Residents with incomes above 300% of the federal poverty limit who do not have access to employer-sponsored insurance, or who have pre-existing conditions that render other coverage unobtainable or unaffordable represent a specific vulnerable population that must be addressed. While Charter Oak may be the best option for this population, Connecticut must develop a means of subsidizing out-of-pocket expenses for premiums, co pays, and deductibles when those out-of-pocket expenses exceed reasonable affordability levels.

- Both the State of Connecticut and the private insurance industry can increase access to affordable and value based insurance by creating opportunities for small businesses and individuals to participate in health insurance pools.
- An Individual mandate for health insurance coverage may represent a logical step in achieving universal coverage. However, it should be considered for implementation only after the necessary consumer protections, regulatory oversight, and benefit design issues have been put into place.

Recommendations for Improving Quality and Transforming Care

Priority recommendations

- Improvement in chronic disease care coordination and management
- Acceleration in the development and implementation of electronic health records and health information exchanges
- Data collection, analysis, and application/use to drive value-based design and health planning
- Health professional workforce planning

Implementation and Responsibility for Health Reform

In making its recommendations, the Authority is mindful of current economic conditions in the state and in the nation. The significant change in economic circumstances since the time the Authority was constituted means that implementation of any recommendations that entail new expenditure of public funds is likely to be delayed, but also gives new urgency to moving Connecticut forward in capturing all possible sources of federal revenue available to it. Many of these recommendations offer this possibility. The Authority is also very mindful of the potential policy changes that are likely to come with President Obama's administration, which may have a significant effect on health policy in Connecticut. In addition, the recently approved federal stimulus package offers the possibility of jump-starting several initiatives in the area of health information technology, workforce training, and expansion of safety net providers such as community health centers. In short, while we are confronted with an immediate urgency related to the state budget, we are also presented with opportunities for real, lasting, and very significant progress towards our goals.

The Authority recommends that a public entity be assigned or developed to better coordinate state spending on health care and to oversee these reforms. Over time it may make sense for this entity to be transformed into an independent body for greater flexibility, but that decision can come at a later date. Initial staffing should come for the most part from existing resources. The entity shall be empowered to call on existing agencies or to create workgroups that can engage people with expertise to tackle particular areas of interest.

This report lays out principles and strategies for achieving universal coverage and indicates possible mechanisms for implementation. Final decisions on the proposed initiatives must await further information on their costs, a better understanding of the dimensions of the current economic crisis, as well as developments at the federal level. Preparations are needed now, however, to ready Connecticut to seize this opportunity to improve the health of Connecticut residents and Connecticut's communities.

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Preface: History of the Authority and its proceedings

The HealthFirst Connecticut Authority was created by the Legislature at the conclusion of the 2007 General Assembly. Broadly speaking, the Legislature created a 10 member healthcare panel and charged it with studying, evaluating, and making recommendations for ways to provide comprehensive health insurance for all state residents. The Authority also was charged with addressing the issues of chronic diseases, electronic health technology, access, safety, and wellness, issues that affect both the insured and the uninsured. The Legislature directed that all members of the HealthFirst Connecticut Authority have knowledge of and consider the Institute of Medicine's principles for both health coverage (insurance) and health care:

> Health coverage shall be continuous, equitable, and affordable for the individual and the society; and health care shall be timely, safe, effective, efficient, and patient-centered.[1]

With this ambitious charge, the Authority undertook its mission of creating a healthy Connecticut through the complementary goals of universal coverage and access to safe, effective care for all Connecticut residents.

Public Act no. 07-185 gave explicit direction to the Authority to consider certain mechanisms for expansion including a single-payer system, risk pooling strategies, individual and employer mandates, affordability, and assistance with premiums. The Bill directed the Authority to consider data and recommendations on wellness, nutrition, disease prevention, and chronic disease management. The appointments to the Authority were under the authority of specified positions; the Governor, Senate President, and House Speaker each appointed two members while the Senate Majority Leader, House Majority Leader, House Minority Leader, and Senate Minority Leader each appointed one member.

The members of the Authority as originally appointed were: Tom Swan and Margaret Flinter (co-chairs), David Benfer, Michael Fedele, Brian Grissler, Mickey Herbert, Sharon Langer, Louis Lista, Sal Luciano, and Lenny Winkler. Additional members were appointed ex officio: Robert Galvin (Department of Public Health), Kevin Lembo (Office of the Health Care Advocate), Michael Starkowski (Department of Social Services), Thomas Sullivan (Department of Insurance), and Nancy Wyman (Comptroller). Michael Critelli was subsequently appointed to fill the vacancy created by Louis Lista's resignation. During the 2008 General Assembly, the Legislature amended the composition of the Authority to formally specify ex-officio representation by the Permanent Commission on the Status of Women, the Latino and Puerto Rican Affairs Commission, and the African American Affairs Commission. A member of each of these organizations, at the invitation of the co-chairs, had been serving on the Authority since its inception.

The Authority moved quickly to establish its two major workgroups – the Cost, Cost Containment and Finance Workgroup (CCCF) and the Quality, Access and Safety Workgroup (QAS) – to guide the Authority to the most informed set of recommendations consistent with its charge. Each workgroup had a consistent and dedicated membership of over fifty individuals representing a very broad range of sectors and interests. All members are integrally involved in health care, whether in promoting health,

[1] Institute of Medicine of the National Academies. Insuring America's Health: Principles and Recommendations. National Academies Press, Washington DC. 2004.

delivering care, improving the patient experience, advocating for consumers and patients, or organizing, financing, and navigating the complex world of health care.

The co-chairs convened the initial meeting of the Authority in October, 2007. The Authority held 27 meetings between October 2007 and December 2008, all at the Legislative Office Building, including 14 meetings of the full Authority and 13 meetings combined of its two major workgroups. During this time the Authority secured the expert testimony of individuals from Connecticut and across the country; reviewed data, reports, articles, and expert panel proceedings on a wide array of pertinent topics; and hosted a series of nine public forums in cities and towns throughout Connecticut.

A full listing of workgroup participants can be found in Appendix 1. A guide to the meeting summaries for all meetings can be found in Appendix 2. A guide to all prepared presentations can be found in Appendix 3. A guide to all source reports, articles, and reference materials assigned for review by the Authority can be found in Appendix 4. Not all meetings of the Authority were filmed by CT-N; those that were are available at www.ctn.state.ct.us or upon request from CT-N. Taped testimony presented at the public hearings was made available by the Universal Healthcare Foundation and is available through that organization.

Introduction

The HealthFirst Connecticut Authority was created to plan for moving the state toward universal health care coverage, while also improving the quality and safety of care and assuring affordability for residents, employers, and the state. It was thus to give life to the principles for coverage and care set out by the prestigious Institute of Medicine. With this report, the Authority completes the first stage of planning. During more than a year of meetings, members of the Authority and its two working groups heard and produced information and ideas from numerous perspectives. They considered the nature and extent of problems along with numerous methods for improvement.

Health care spending is relatively high in Connecticut, though similar to neighboring New York and Massachusetts. As elsewhere, costs are increasing rapidly, and current trends are unsustainable over time. Unless value of Connecticut's health spending can be improved going forward, both public and private health plans will be hard pressed even to retain today's level of coverage compared with other states.

The central problem is that the now-traditional systems of care and coverage suffer from a "paradox of excess and deprivation."[2] That is, many residents have excellent coverage, and some receive care even beyond what is useful and appropriate. At the same time, a substantial minority lack regular coverage and a regular source of care. Numerous others who have insurance worry that they could lose it because of job loss or a deterioration in health status.

There is evidence that even well insured people do not always receive care that is consistent with evidence based guidelines. They may receive too little care, the wrong care, unsafe care, and care is not care well coordinated across disparate practitioners and settings.

The central reform strategy discussed by the Authority is to create mechanisms and incentives that over time will transform the health care delivery system so as to keep existing coverage and care affordable, while improving quality and health. Affordability is key for those who currently have coverage, to be able to add coverage for those now uninsured, and for the public sector. Expansion of coverage has been suggested through three basic mechanisms—enhanced Medicaid at the low end of family incomes, modified Charter Oak coverage for middle incomes, and the Health Partnership (piggy-backing on a modified version of the state employees insurance program) mainly at the upper end, although ultimately to be opened to all. Coordination of health policy goals needs to occur across all state-supported health plans and public health initiatives, so that consistent signals and supports can be provided to practitioners and patients alike. The goal of these mechanisms is not to replace existing successful private market health insurance plans, but to create mechanisms to expand affordable comprehensive health insurance coverage to those who do not have it today. Final recommendations must await estimates of the impact of expansion options on the number of people covered and on state and private costs, under various assumptions. This report sets out principles to help guide succeeding design choices, notably including value-based health plan design, which provides incentives to increase adherence to medically necessary disease treatment plans, increase usage of high value preventive care,

[2] The phrase comes from Alain C. Enthoven and Richard Kronick, "A Consumer Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy, I." *New England Journal of Medicine* 325 (1989):854-59 (first of two parts).

reward healthy behaviors, and discourage the use of poor or unproven services, and share responsibility for financing and for changing accustomed patterns of behavior. As always, but especially in the current economic conditions, trade-offs will be required among the various goals in the Authority's vision. Both decision making on final recommendations and implementation planning thereafter call for new approaches to be taken within existing public entities, possibly with a new coordinating or oversight entity. Successors to this Authority will make the final tradeoffs needed to balance responsibilities of individuals, families, employers, practitioners, and the public.

This report does not provide a blueprint for reform. It does, however, set out a roadmap to reform that identifies areas for further work and principles to help guide decision making further along the road.

Overview of Health Insurance Coverage in Connecticut

As presented in the recommendation section of this report, the Authority has taken a "building blocks" approach to expansion of insurance coverage. That is, it decided to build on the existing structure of coverage, both private and public, to ensure that every resident has access to an affordable insurance product, and to improve the existing insurance products to better meet residents' needs. The following brief description of existing coverages and their related issues sets out the starting point for expansion and identifies the problems that the Authority sought to address in its recommendations.

Figure 1. Insurance status of Connecticut Residents, by income and eligibility category

Number of Uninsured Connecticut Residents Aged 0-64 by Family Income, Eligibility Category and Work Status						Number of Insured Connecticut Residents Aged 0-64 by Family Income & Insurance Source		
Family Income (% FPL)	Program Eligibility Category		Work Status		Total uninsured	Source of Insurance		Total Insured
	Children & Parents	Non-parents	Full time, full year	Part-time/Non-worker[a]		Medicaid/ SCHIP	Private[b]	
0-99	45,000	65,000	not presented*		110,000	165,000	115,000	280,000
100-199	36,000	59,000	34,000	61,000	95,000	104,000	176,000	279,000
200-299	23,000	41,000	32,000	32,000	64,000	42,000	287,000	329,000
300+	28,000	44,000	37,000	35,000	72,000	44,000	1,739,000	1,783,000
Total	133,000	209,000	112,000	229,000	341,000	355,000	2,316,000	2,672,000
Based on data from a merge of the 2006, 2007 and 2008 Annual Social and Economic Supplement to the CPS. Note: Date may not sum to totals due to rounding. *Estimates are not reliable due to insufficient sample size. [a]Part time includes full-time part year, part-time full-year, and part-time part-year workers.						Based on data from a merge of the 2006, 2007 and 2008 Annual Social and Economic Supplement to the CPS. Note: Data may not sum to totals due to rounding. *Estimates are not reliable due to insufficient sample size. [b]Private includes other federal coverage.		

Compared with other states, Connecticut has a relatively low percentage of residents without insurance. Uninsurance is concentrated among low income groups. But, as seen in Figure 1, many low income residents have private coverage and many residents eligible for public coverage are uninsured. A relatively high share of employers offers health coverage in Connecticut (93.6% versus 86.9% nationally).[3] The average cost of employer coverage is relatively high ($12,416 in CT versus $11,381 nationally) as is employee contribution to family coverage ($2,947 in CT versus $2,890 nationally).[4] However, average income is also relatively high so that premiums represent a somewhat smaller share of employee incomes in Connecticut than nationally (4.9% in CT vs. 6.0% nationally).[5] Currently, health care expenditures in Connecticut total about $24 billion annually, of which $7 billion are state expenditures.[6]

[3] Axeen S, Carpenter E. The Cost of Doing Nothing: Why the Cost of Failing to Fix Our Health System is Greater than the Cost of Reform. New America Foundation, November 2008. Available at http://www.newamerica.net/files/NAF_CostofDoingNothing.pdf.
[4] Axeen and Carpenter 2008
[5] Axeen and Carpenter 2008
[6] State of Connecticut

Insurance markets and regulation

Regulation affects the terms of insurance contracts and the distribution of premium burdens across classes of purchasers or enrollees. Ideally, reformers should be cognizant of current market conditions, including regulation, so they can appreciate how any reform's health plans differ from existing plans in extent of benefits and likely prices for different types of enrollees. The nature and extent of differences will affect who enrolls and the extent of public subsidy needed to keep reform plans affordable to enrollees.

Health plan design and prices are driven by market demand but influenced by a mix of state and federal rules. All fully insured plans must provide benefits that are mandated by the state, such as childhood vaccinations or direct access to OB/GYNs (without prescreening by a gatekeeper). How much other regulation there is, especially of enrollment and pricing, varies by market segment.

Coverage bought by individuals, for themselves or their families in Connecticut is state regulated. Regulation is not extensive, however. Plans are not required to sell to applicants (there is no "guaranteed issue" of coverage). Plans are also free to charge different rates according to their assessments of an applicant's likely spending—basing judgments heavily on age and health risk. Individuals rejected for coverage are entitled to buy into a "high risk pool" that is industry-run but overseen by the state, at premiums that are industry-subsidized but still above-normal rates. People who have lost group coverage are, by federal law, also entitled to buy in. The pool now has about 2,500 enrollees. In all, more than 130,000 people have individual coverage, some 5 percent of people under age 65. Many of them would likely be attracted to reform coverage that features community rating (all enrollees pay average rates)—particularly individuals or families that are now paying high rates because of age or health history.

Employer sponsored insurance (ESI) coverage bought by small employer groups, those with 50 or fewer employees, faces more extensive state and some federal regulation. Connecticut is among a minority of states to allow a "group of one" to buy small group coverage on the same terms as larger small firms, giving sole proprietors easy access to coverage and much more favorable rates than in the individual market. Several important regulations apply for small groups. According to state and federal law, insurers must sell any available plan to all applicants (guaranteed issue). Premiums are set by adjusted community rating; prices may vary by age, gender, and other accepted characteristics, but not by health status or history. People in the small group market face rating rules that are much closer to likely reform rates, so the incentive to switch plans would generally be less than for individuals.

Coverage bought by large groups is little regulated, other than by benefit mandates. Self-insured groups are not regulated by states at all, and only to a limited extent by federal rules (such as the recently enacted mental health parity) because federal ERISA law "pre-empts" state regulation. Just over half of Connecticut private-sector enrollees are in self-insured plans, the same as in the nation at large.[7] Detailed analysis is needed to assess which large groups might want to shift to a reform plan.

[7] 2005 data from the federal Medical Expenditures Panel Survey of employers.

Employer-sponsored coverage

The majority of Connecticut residents are insured. Employer-sponsored insurance (ESI) is the dominant form of health insurance coverage in the state; 85% of insured residents under 65 have coverage through an employer, either their own or through a spouse or parent. These individuals are reported both nationally and in Connecticut to be generally satisfied with their coverage, though increasingly anxious about their vulnerability to changes in coverage. The state of Connecticut is an employer and, as such, it provides insurance to its workers through its employees' insurance programs.

While ESI is typically good coverage, its connection with employment is associated with some risk. Workers with ESI are at risk of loss of insurance if they lose their job or if poor health reduces their ability to work. Escalating premiums and out-of-pocket expenses, and the potential for hitting the lifetime maximum in health payments based both on the policy and catastrophic illness add financial uncertainty, as do changes in benefits and exclusions for particular conditions. From the perspective of the employer, rising costs and, for small employers especially, the unpredictability of premium increases have made the provision of insurance more difficult each year. In addition, the costs of finding affordable policies and administering health coverage for employees can represent a significant burden, especially for small businesses.

Underinsured

The high share of the population with insurance coverage may not be an accurate representation of the need for coverage expansion. Many insured residents have deductibles, co-payments, and other out-of-pocket health care expenses that are very high relative to their income and their health care needs. Most of these residents, while not found in the uninsured statistics, should be considered underinsured.

According to the United States Census Bureau, there are currently about 25 million underinsured Americans.[8] However, because there is no standard definition of the term "underinsured," it is difficult to estimate the size of this problem in Connecticut. Generally, the term "underinsured" is used to describe individuals who are at risk of significant financial losses as a result of inadequate health insurance coverage. Like the uninsured, the underinsured are generally people who work for small employers, have lower incomes, and are in poorer health. People with non-group policies are more likely to be underinsured than people covered by group insurance plans, because affordable non-group policies are frequently characterized by higher cost-sharing and less generous benefit packages.

Young adults (ages 19-24) and adults near retirement (ages 55-64) are disproportionately represented within the uninsured and underinsured population. Lack of insurance coverage for all groups creates barriers in access to care and exposes the underinsured to the risk of high medical bills. Young adults are a fairly healthy group, but because health needs generally rise with age, adults near retirement are at greater risk of incurring high bills.

[8] Schoen C, Collins SR, Kriss JL, Doty MM. How many are underinsured? Trends among U.S. adults, 2003 and 2007. Health Aff (Millwood). 2008 Jul-Aug; 27(4):w298-309.

Public coverage programs

The Division of Medical Care Administration and Regional Offices of the Department of Social Services ensures that eligible children, youth, adults, and seniors are able to access needed medical and/or prescription medication coverage through Medicaid, the State Children's Health Insurance Program, the State-Administered General Assistance medical program (SAGA), ConnPACE, and other programs, including the new Charter Oak program. Connecticut's HUSKY Managed Care Plan (Healthcare for UninSured Kids and Youth) combines services under Medicaid and the State Children's Health Insurance Program (SCHIP) for eligible children, teenagers, pregnant women, and parents/caregivers. Medicaid fee-for-service coverage is provided to eligible elders and people with disabilities of very low incomes, while State-Administered General Assistance offers medical coverage to eligible adults. HUSKY A is the state's Medicaid program for low income children and families, while traditional Medicaid covers aged, blind, and disabled citizens. HUSKY B is the state's SCHIP program and is also a joint state-federal program. SAGA and Charter Oak program are state-only programs, although federal Disproportionate Share Hospital (DSH) payments help support hospitalizations for SAGA enrollees. In total, around 470,000 people, about 13% of the state's population, are covered by these programs.

Benefits in HUSKY and traditional Medicaid, reflect federal requirements and are generally comprehensive. The federal government pays 50% of Medicaid expenditures and 65% of SCHIP expenditures. Medicaid and HUSKY enrollees have varying degrees of success in finding providers to deliver the care authorized under the benefit package, both primary and specialty care. Access to certain providers and services, such as obstetrics and pediatric primary care is generally good, while access to primary care for adults and specialty care for all age groups is often difficult. Access to dental care is challenging for all groups. The state's federally qualified health centers and hospital primary care clinics are major providers for these populations. Benefits under SAGA are less generous, and access problems are acute. Charter Oak is funded through a combination of state funds and individual contributions and like SAGA, has significant limitations, including limitations in coverage, high cost sharing and annual caps, and provider access.

The elderly, with access to Medicare and, in some cases, Medicaid represent the final group of insured residents. Rising co-payments and deductibles for Medicare hit seniors on fixed incomes especially hard.[9] This group is more likely to have multiple medical conditions requiring care. Lack of coordination of services means that this care is often not optimal, costing more than it needs to and with more frequent complications. The elderly, particularly members of minority populations, are disproportionately represented in hospital admissions for ambulatory sensitive conditions, and that is worse for minority populations. (Because nearly all seniors are eligible for Medicare and the state does not have any jurisdiction over the program except regulation of Medicare supplemental rates, the Authority did not consider Medicare coverage explicitly. Medicare beneficiaries were considered in measures to improve quality, safety, chronic disease management, and in efforts to identify and eliminate health disparities.) As the table 1 shows, one can look at emergency room utilization per

[9] The burden of health care spending on the elderly has increased since the mid-1990s. In 1994, 23 percent of the elderly spent more than 20 percent of their incomes on health care; that number had increased to 28 percent by 2004. (Personal communication, Stephen Zuckerman, Principal Research Associate, The Urban Institute).

1,000 members in each of the insurance categories and reasonably conclude that publicly insured patients are turning to the ED as a regular source of care.

Public program eligibility

HUSKY is divided into two plans: HUSKY A and HUSKY B. HUSKY A provides health services for low income children under age 19, pregnant women, and some parents or relative caregivers of covered children, the so-called categorically eligible in Medicaid. The income eligibility standard varies by category: children and parents or relative caregivers must have family incomes under 185% of the FPL (currently, $32,560 for a family of three); for pregnant women, the standard is 250% of the FPL ($44,000 for a family of three; pregnant woman counts as two). As of January 2009, there were 223,443 children and 108,076 adults enrolled in HUSKY A.

Table 1: ED Utilization Rates by Payer Category, FY 2006, Source: OHCA Hospital System Task Force Report, 1/3/2008

Payer Category	# visits/1,000 population
Privately Insured	250
Uninsured Patients	455
Medicare	615
Medicaid Managed Care	791
Medicaid FFS	1,092
SAGA	1,578

HUSKY B (SCHIP) provides subsidized health insurance for children whose parents make between 185% and 300% of the FPL, which is deemed too much money to be covered by Medicaid but not enough to buy private insurance. Some families pay a subsidized premium of $30 for one child/month or $50 for two or more children/month and all families pay co-pays for some services. Children in families with incomes above 300% of the FPL may also enroll in the HUSKY B program, but they must pay the full cost of the program (about $200 a month per child). As of January 2009, there were 13,960 children enrolled in HUSKY B.

SAGA provides medical assistance to very low-income residents who do not qualify for other state or federal programs. Enrollees in SAGA must have monthly income below $506.22 to $610.61, depending on where in the state they live, and can have assets of no more than $ 1,000. As of October 2008, there were approximately 32,000 Connecticut residents receiving SAGA medical assistance.

The categorical eligibility standards in HUSKY meant that many adults who did not have ESI were not eligible for public coverage. Charter Oak Health Plan (COHP) was created in 2007 by Governor M. Jodi Rell's administration to provide universal access to affordable health care coverage to Connecticut adults of all incomes. Charter Oak has no income limits, and there are no exclusions for pre-existing conditions, so anyone can qualify. Although there are reduced premiums and deductibles for low income individuals, there are significant out-of-pocket expenses in premiums, co-payments and deductibles, as well as a cap on the amount of medical expenses the plan will cover (no more than $100,000 a year and no more than $1 million in a lifetime). As of December 1, 2008, there are 2,687 members enrolled in one of the three managed care organizations that offer coverage under the Plan.

Rate of growth in enrollment and in costs

Current state spending on these public coverage programs is expected to be about $5 billion in 2008, almost double the expenditures from ten years ago (not adjusted for inflation). Health expenditures

currently represent 38% of state expenditures, up from 33% ten years ago.[10] Enrollment in public programs has also grown over the decade. In June, 1997, there were about 310,000 Medicaid enrollees in Connecticut; in June 2005, there were about 407,000.

Issues

While the benefits in the state's HUSKY programs are generally very good, enrollees often have difficulty finding providers who will see them, in large part, because of the low reimbursement rates. The fee schedules for Medicaid, HUSKY and SAGA vary, and provider participation rises with fees—the closer the fee comes to meeting commercial rates, the higher the physician participation. Obstetrical care and many pediatric services have rates approximating commercial payers and participation is adequate. The fees schedules for adults on HUSKY and the Charter Oak Health Plan are far below even Medicare rates. Recent increases in dental reimbursement brought a significant increase in HUSKY program participation by dentists, but it must be noted that this applied only to pediatric dental care and not to the care of adults. Adult dental rates remain at approximately 52% of pediatric rates for the same services.

A lack of participating providers both in the primary care specialties and in the sub-specialties creates access and care issues. The state's network of community health centers (FQHCs) and the primary care clinics of several hospitals are a major source of care for the population, but have trouble getting specialty referrals when needed. The FQHCs, with a specific model and mission focused on vulnerable populations, are reimbursed based on a prospective payment system and are located in areas of highest need in the State. They face capacity issues, are not located in every community in need, and cannot meet the demand for care by the entire publicly insured population. Both ambulatory and inpatient health care providers and organizations assert that payments under public insurance programs do not meet the cost of providing care. The consequence of underpayment relative to costs incurred by the publicly insured added to the uncompensated costs of care for uninsured residents, must be recouped if the clinics, hospitals, and other providers are to continue to pay their bills. Frequently, meeting costs requires increases in charges to those with private health insurance, a practice often called "cost-shifting." The issue of payment rates is also proving to be a significant challenge for the Charter Oak program, with fees generally set by the managed care organizations at a level approximating the Medicaid adult fee schedule. In addition, providers must collect significant co-payments at the point of service, which adds administrative time to each patient visit and risks non-payment.

Another issue in the HUSKY program concerns the type of health insurance model to be applied. Since January 1, 2008, this program has been run either directly by DSS or through one of several HMOs. These HMOs are paid on a non-risk basis to administer all Medicaid or SCHIP covered services to the HUSKY A and B populations, with all policy decisions made by DSS. Prior to this date, the HUSKY program was run under a risk-based HMO model. DSS is now moving the HUSKY population back into risk-based entities. At the same time, DSS is beginning to administer a non-HMO model of healthcare delivery, Primary Care Case Management or PCCM. In 2008, the HMOs were not responsible for providing pharmacy and dental services. As with behavioral health services, pharmacy and dental have been "carved out" from managed care and administered by DSS through private non-risk contractors. As seen in figure 1, many residents who are eligible for public coverage are not enrolled. The reasons for

[10] State of Connecticut

failure to enroll or re-enroll vary across families. Nationally, administrative barriers have been shown to be a significant factor, but there are undoubtedly other circumstances that contribute as well.

Uninsured

A 2008 Office of Legislative Research Report estimates that there are approximately 325,000 Connecticut residents, about 9% of the population, without healthcare coverage.[11] This figure represents a 2% drop from a prior period, thought to be attributable to a small increase in people with private coverage and a larger increase in people with public coverage. Children represent 17% of uninsured in Connecticut. Men are more likely than women to be uninsured. Minorities are disproportionately represented among the uninsured. Twenty-two percent of Hispanics are uninsured and 18% of blacks, compared with only 8% of whites. According to the OLR report, 40% of the uninsured have incomes above 200% of FPL.

Consequences of un- and under-insurance

The consequences of being uninsured, under-insured, or insured without access to care, are profound in their human, social and economic burden. It can be deadly: The Institute of Medicine estimates that lack of health insurance contributes to 18,000 deaths per year. The uninsured are less likely than the insured to have a regular source of care, less likely to receive preventive care, and less likely to benefit from early detection of medical problems.[12] Employers lose when employees are absent from work. Just in the area of oral health, 16% of the uninsured missed work during the year because of a dental problem.[13] In Connecticut, hospitals bear the financial brunt of uncompensated care (both charity care and bad debt), which was reported to total $191 million in 2007.[14]

There is also a huge human and economic toll associated with having insurance but no access to a regular source of primary care or "medical home". In 2006, there were some 48,000 hospitalizations nationally that might have been prevented if the patient had had access to primary care,[15] at an estimated cost of nearly $1 billion dollars. For the uninsured and the under-insured, these costs often add to hospital providers' uncompensated care burden. The total costs to the health system, beyond the costs of hospitalizations, have not been fully documented. Many of these costs are to be found in foregone prevention and early treatment and in higher utilization of the Emergency Department for primary care.

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[11] Data from 2004-2007. Backgrounder: Health Care Coverage and the Uninsured in Connecticut, Office of Legislative Research Report, September 30, 2008. Available at http://www.cga.ct.gov/2008/rpt/2008-R-0548.htm.

[12] Beal AC, Doty MM, Hernandez SE, Shea KK, Davis K. Closing the Divide: How Medical Homes Promote Equity in Health Care. The Commonwealth Fund, June 2008. Available at http://www.commonwealthfund.org/usr_doc/Closing_divide.pdf?section=4056.

[13] Davis K. Commentary. Medical Care Research and Review, Vol. 60 No. 2, (Supplement to June 2003) 4056. Available at http://www.kff.org/uninsured/upload/Supplement-Commentaries.pdf. Commonwealth Fund's 2001 Health Insurance Survey

[14] OHCA 2007 Report to the Legislature, April 2008.

[15] Preventable hospitalizations are defined as instances of inpatient hospital care for ambulatory care sensitive conditions (ACSCS) that are considered "preventable" because timely and effective primary care and medical management have been clinically demonstrated to reduce the need for hospitalizations. (Office of Health Care Access 2008 Preventable Hospitalizations in Connecticut).

Impact of coverage structure on providers

Reimbursement rates vary across payers. State and state-federal programs generally have the lowest payment rates, and commercial insurance plans the highest. Providers must meet their costs in order to stay in business. Many balance lower payments from public programs with higher payments from commercial insurance or with grants and contributions from philanthropies. Therefore, providers are concerned not just with the level of payments but also by the distribution of payers across their patient population, their "payer mix". If the share of the population covered by public programs rises without an adjustment in the reimbursement rate, providers must either charge a higher rate to non-public program enrollees, which is not always possible, or reduce the number of public program enrollees they care for. Alternatively, they must reduce their costs to a level that reflects available revenue. A reduction in the number of uninsured will reduce provider uncompensated care costs. Reduction of other costs can be difficult for individual providers to achieve. Transformation of care delivery at the provider level as well as throughout the health care delivery system is needed to achieve this goal.

Overview of Healthcare in Connecticut

Each insurance status comes with its own set of issues but all residents access care under the same general health care system. Inadequate payment rates under Medicaid and uncompensated care provided to the uninsured often lead to cost-shifting to the privately insured. Inefficient care for one group affects care and costs for the others. Whatever their insurance status, all groups face the same issues: cost, cost containment, and financing of healthcare; and quality, access, and safety. Coverage expansions and health care system reform must go hand in hand. Improving the system will result in a better use of health care funds across all groups. Finally, while medical insurance dominates public concern, there is an equal and persistent issue of access to and coverage for dental care, which is integrally associated with health, but not integrally associated with health insurance.

Beyond the sometimes precarious nature of good insurance coverage and the inefficiencies in the provision of care to the uninsured are the problems of the health care delivery system. In the ambulatory setting, many insured and uninsured residents lack access to what is called a "medical home" or a high performance health system, one that gives full attention to prevention and health promotion, care coordination and case management of chronic disease, access to care outside of regular office hours, and coordination across transitions to specialist and inpatient settings. In the inpatient setting, issues of quality, safety, and management of the transition back to the community are equally problematic. In all settings, there are missed opportunities for timely interventions and an emphasis on diagnosis and treatment over prevention and disease management. Furthermore, uninsurance and under-insurance are related not only to income but also to racial and ethnic differences.[16] Thus, while some of the best care in the world is available in Connecticut, it is not equally available and uniformly practiced, leading to significant disparities in health outcomes.

Support for health system reform is growing across the political spectrum. The New American Foundation, for example, noted the following in a recent report:

> The moral case for health care reform is well documented. The uninsured live sicker and die sooner than the insured. People who are uninsured often forgo necessary care because of cost and sink into financial ruin because of health care bills. However, health care reform is not just a moral imperative; it is also an economic necessity.[17]

The Association of Health Insurance Plans sounded a similar refrain in its recent report:

> Although those without insurance suffer the most, we all pay an increasingly intolerable price for the gaps in coverage that characterize the health care system in the United States today. Needless costs include the tragedy of inadequate prenatal, infant, and child care; the expense and complications of acute care instead of prevention; widespread failure to proactively treat chronic illnesses; lost productivity from untreated or inadequately treated medical conditions; and, as a result of all of

[16] The Connecticut State Conference of NAACP Branches Health Committee. A Health Status Report on African Americans in Connecticut. October 2007. Available at http://www.universalhealthct.org/admin/uploads/135014718ad5660ded2.28713584.pdf.

[17] Axeen and Carpenter 2008

> these problems, rampant cost-shifting from the uninsured to all those who must ultimately pay the bills for their unaddressed conditions and substandard care—a huge burden for hospitals, physicians, employers, insurers, governments, charities, and taxpayers. The access crisis has profound consequences. It inflicts hardship on millions of families, strains the social fabric of our nation, and undermines our economy. We are less productive, less secure financially, and less healthy because of it. [18]

There are inadequate incentives in the health care system currently to address the issues of quality, cost, and value. The resulting inefficiencies add costs to the bill of everyone who uses the system. Looking at the high cost of health care, it is difficult to imagine expanding coverage without simultaneously addressing the drivers of health care costs. Universal coverage within the current inefficient system could be prohibitively expensive. But the burden of care for uninsured residents contributes to this high estimated cost. **Expanding coverage and transforming care must go hand in hand**.

Costs – increasing and unsustainable

The relationship between higher-priced healthcare, better healthcare, and better health outcomes for the population is not consistent. In an international context, the United States spends more per capita on healthcare but has worse health status on multiple indicators, from infant mortality to life expectancy.[19] For decades now the cost of healthcare in the United States has been rising at a rate higher than that of inflation. The reasons for this escalation are numerous. According to Bodenheimer and colleagues, the most important is that Americans simply pay more to nearly everyone involved in delivering health care. He notes that there has also been an increase in the use of expensive technology (MRIs, for example), and that the US health care establishment has done little to apply the science of treating and managing multiple chronic conditions and co-morbidities to the art of practice redesign, team-based care, and chronic disease management.[20]

The increases in costs per person are compounded by changing demographics. The population is aging and the incidence and prevalence of chronic disease—often multiple chronic diseases—is rising. The impact of chronic diseases and of insufficient effectiveness in prevention, early detection, management, patient education, and coordination of care for patients is likely to consume ever greater share of the healthcare dollar without new models, innovations, and interventions.

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[18] AHIP, We Believe Every American Should Have Access to Affordable Health Care Coverage, A Vision for Reform, Available at http://www.americanhealthsolution.org/assets/Uploads/ahipcoverage.pdf, accessed 5 December 2008.

[19] United Health Foundation. America's Health Rankings: A Call to Action for Individuals and Their Communities, 2008 edition. Available at http://www.americashealthrankings.org/2008/pdfs/2008.pdf.

[20] Bodenheimer T. High and Rising Health Care Costs, Parts 1-4. Annals of Internal Medicine. 2005; 142 and 143. Available at http://www.annals.org/cgi/content/full/142/10/847,
http://www.annals.org/cgi/content/abstract/142/11/932,
http://www.annals.org/cgi/content/abstract/142/12_Part_1/996,
http://www.annals.org/cgi/content/abstract/143/1/26.

Technology

The increased use of technology noted by Bodenheimer has been largely positive for improving health. The advances in diagnosis and treatment made possible by inventions such as MRI scanners and by the development of techniques such as non-invasive surgery benefit all of society. So, Americans are paying more, but they are getting more. The relevant question is less whether the individual technologies are providing health benefits but rather whether spending in the health sector overall across technologies and services is distributed so as to maximize the overall return on the health care dollar. Careful examination of this question is likely to show over-investment in some services and under-investment in others.

Information technology

Information technology is one area where increased expenditure has the potential to improve the return on investment in health care with respect to health outcomes. A recent analysis by the Congressional Budget Office (CBO) concluded that "health IT appears to make it easier to reduce health spending if other steps in the broader health care system are also taken to alter incentives to promote savings." However, the CBO report cautions that "by itself, the adoption of more health IT is generally not sufficient to produce significant cost savings."[21]

Better medical data and information technology (e-records, e-prescribing, health information exchange, CCR) in Connecticut could contribute to resolving cost and quality problems While nearly all practices have computerized billing and practice management systems, it is estimated that only about 25% of practices have a fully electronic health record. Only one FQHC in Connecticut has a fully implemented electronic health record that integrates medicine, laboratory and pharmacy data. Most of the states' other FQHCs are at various points in the planning process for the implementation of EHRs. Several physician practices utilize registry systems to track and monitor care for patients with chronic diseases and many providers utilize electronic prescribing even in the absence of an electronic record. Fully integrated EHRs could contribute to improved efficiency of the system with salutary effects on both cost and quality but there is no guarantee to provider or practice of a positive return on the investment. Partial solutions, such as chronic disease registries and electronic prescribing, have been adopted by some practices. The lack of uniform adoption within delivery systems means that practices that do use EHRs face barriers in communicating and sharing information as patients transition across care settings. eHealth Ct. is a private non-profit dedicated to addressing the need for health information exchange in Connecticut. In addition, the state's Department of Social Services is actively engaged in supporting a similar initiative for federally qualified health centers.

The Veterans Administration system, along with other organizations such as Kaiser Permanente and Geisinger Health System, have demonstrated the power of electronic health records to influence transformations in quality care through monitoring of both the performance of individual providers and groups of providers and the clinical outcomes of patients. Key barriers to universal adoption of electronic health records include initial expense, uncertain return on investment, reluctance to change and adopt new technologies, lack of technical support to accomplish purchase, training, and

[21] CBO, Evidence on the Costs and Benefits of Health Information Technology, Washington, DC, May 2008. Available at http://www.cbo.gov/ftpdocs/91xx/doc9168/05-20-HealthIT.pdf.

implementation, and perhaps a perception that the field has not yet stabilized enough for prudent investment.

Role of public health in prevention and in reducing the need for care

The focus of the HealthFirst Connecticut Authority is on healthcare coverage, and access to care that is effective, safe, and of high quality. The greatest gains in preventing disease and controlling costs are far more amenable to public health, community-based, and education interventions than to interventions conducted in the clinical setting and covered by insurance. Preventing tobacco use, supporting tobacco cessation efforts, improved nutrition, increased physical activity, social engagement, safe neighborhoods, and health literacy are all essential elements of improving the health of Connecticut residents.

Quality and safety of care

Information on quality or safety throughout the entire health care system is currently insufficient. Quality and safety are the foremost concerns of every provider and hospital, but there are limited metrics for evaluation that cover all patients, all payers, and all settings. Medicare has taken steps to publicly report on specified quality measures. In Connecticut, the Department of Public Health has established quality reporting measures for hospitals as well as requirements for reporting adverse events. All healthcare organizations have internal quality improvement programs. The Office of Health Care Access has begun an initiative to solicit out-patient health care data. Practices that participate in various pay-for-performance programs, as well as those with their own electronic health records or disease registries, are able to produce and use clinical quality outcome data. However, there is no way to fully assess and compare safety and quality data across all patients and settings at this time.

Disparities

Multiple reports document the persistence of significant health disparities by race, ethnicity, and type of insurance in the state of Connecticut.[22] There is strong evidence that membership in a racial or ethnic minority group combined with having public or no insurance is associated with poorer health status, reduced access to primary care, worse outcomes of chronic diseases, and greater likelihood of hospital admission for ambulatory care-sensitive conditions. Furthermore, racial minorities are less likely than Whites to receive certain diagnostic and life-saving procedures. More Whites than Blacks have a personal doctor or primary care provider, and far more Blacks than Whites use the emergency room when they become ill. Minorities account for over half of increased ambulatory care sensitive conditions hospitalizations.[23]

There is cause for cautious optimism in the research done by the Commonwealth Foundation documenting that elimination in racial and ethnic disparities in health *care* can be substantially reduced

[22] See, for example, Alison Stratton, et al., Issue Brief – Defining Health Disparities, The Connecticut Health Disparities Project, CT Department of Public Health, Hartford, CT, Summer 2007. Available at http://www.ct.gov/dph/lib/dph/hisr/pdf/defining_health_disparities.pdf.

[23] CT Office of Health Care Access, DATABOOK: Preventable Hospitalizations in Connecticut: *An Updated Assessment of Access to Community Health Services FYs 2000 – 2006, April 2008. Available at* http://www.ct.gov/ohca/lib/ohca/publications/2008/prev_hosp.pdf.

or even eliminated if the individual has a medical home in a high performance health system.[24] This underscores, once again, the critical importance of both coverage and access.

Workforce issues

There are serious issues looming in the health workforce in Connecticut across all types of healthcare professionals. The shortage of registered nurses as well as other healthcare professionals has been recognized for years, but the looming issue of physician shortages in both primary care and some other specialties is now emerging. The experience of Massachusetts demonstrated that expanding coverage will also expand demand upon the existing primary care providers of the state. There are issues in recruitment of new physicians to replace an aging physician workforce as well as in the distribution of providers across the state. The Statewide Primary Care Access Authority, which has operated in tandem with the HealthFirst Ct. Authority, holds the responsibility for making detailed recommendations about the primary care workforce and strategies to strengthen it. The SPCAA will submit its report in 2009. Serious investments in workforce planning, education, retention, and consideration of changes in scope of practice will be called for. It is clear from the Authority's multiple public hearings that Connecticut's healthcare providers—of all types—want to be part of solving coverage, access, and care issues.

[24] Beal et al., 2008.

Statement of Vision

The work of the Health First Ct. Authority must start with a vision, and that vision is to protect, improve, and maintain the health of all people of Connecticut. Connecticut will accomplish this through both short term and long term efforts. These efforts include:

1) Making prevention a priority
2) Promoting personal responsibility and empowering individuals to engage in healthy behaviors and lifestyles
3) Ensuring access to a medical/healthcare/dental home for every Connecticut resident.
4) Ensuring that every resident has access to group-based public or private health coverage that is affordable to the individual, family, and state
5) Ensuring that both health insurance coverage and healthcare meet the IOM principles: timely, safe, patient-centered, equitable, sustainable and effective.
6) Eliminating health disparities

Throughout its work, the Authority has consistently reviewed evidence that suggests that current expenditures are not sustainable into the future, and care is neither as equitable nor as effective as it should be. The result is that the residents of Connecticut are not getting as good a return on investment in healthcare as they could. We can do better.

Therefore, the fundamental principle underlying the Authority's recommendations for enacting universal coverage and effective care is that it be value-based—value for the health and wellness of both individuals and communities, value in the return on the financial investment by taxpayers and other payers, and value in the realization of a just and equitable approach to health care for all. Value-based benefit design means that the Plan contains varying degrees of coverage for different treatments based on clinical effectiveness and health benefit of each treatment, and that plan provisions are adjusted from time to time as expert medical opinion on treatments change. Value-based design incorporates features that emphasize wellness, prevention, early detection of disease, optimal management of chronic disease, personal responsibility, and self management. Value-based design will also apply to pharmaceutical policy. Value-based benefit design includes coverage for essential oral health/dental services, and timely access to appropriate behavioral health services, including substance abuse treatment. Accomplishing this goal requires transformation and innovation in the way care is organized and delivered, in how and what is paid for, and in the measurement and evaluation of the progress made.

Underlying principles of care

The principles of care underlying this vision are

- Access to Care: access to care must be patient centered, culturally competent, coordinated, delivered close to home, with health promotion and disease prevention integrated into care at all levels. When referencing care and coverage, the Authority is referring to medical, dental, and

behavioral health care as equally vital components of health care and health insurance coverage.

- Quality and Efficiency in care: care in Connecticut must be timely, delivered at the right level, be evidence based, and produce the most positive clinical outcomes possible for the individual
- Affordability and sustainability: the financing of health care and health promotion in Connecticut should be equitable, seamless, and sustainable for consumers, providers, purchasers, and government
- Health and wellness: Connecticut must create a strong culture of personal responsibility for healthy lifestyles and use the weight of its influence to support the elimination of tobacco smoking, the prevention of obesity, the adoption of healthy diets and active lifestyles, and the reduction of violence and environmental threats
- Stewardship: the State of Connecticut must establish a framework and structure to administer health care resources with the highest level of integrity, responsibility, and transparency
- Consumer control, engagement, and activation: that Connecticut residents must be active, activated, and involved consumer of care and shapers of public policy in developing an improved health care system for all
- Adaptability and flexibility, ready to respond to new federal initiatives in health care reform that support this vision.

Underlying principles of coverage

The principles of coverage underlying this vision are**:**

- Availability
- Affordability
- Evidence-based benefit structure
- Value-driven in accordance with and supportive of the principles of care.
- Accountability

Approaches considered

The Authority considered a wide range of alternatives for coverage expansion. Specifically, the Authority considered a single payer system, a bolstered employment-based system, insurance choice/pooling, regionally organized networks of care, and universal entitlement to primary care with insurance coverage for inpatient care only. The Authority also considered imposition of an individual mandate for the purchase of insurance. The discussions surrounding each of these are presented briefly here. In light of these considerations, the Authority opted for a building-block approach to coverage expansion, building on existing private and public coverage.

Single payer: There are compelling reasons to move in the direction of a new universal entitlement to publicly financed healthcare coverage. These include a reduction or elimination of problems associated with transitions in coverage due to change in employment, income, or family status, and elimination of adverse selection and crowd out as concerns. However, the Authority recognized that it could not achieve consensus on a single payer system.

Insurance choice/pooling: New pooled insurance products could purchase coverage collectively on behalf of a large number of individuals and negotiate from a position of strength with a variety of health plans. The potential benefits of this arrangement and the substantial work that has gone into developing such an option in Connecticut argued for inclusion of some elements of this option in the final recommendations.

Regionally organized networks for care: A universal health system based on regionally organized networks of care would target the uninsured and would emphasize prevention and coordinated care. While the success that San Francisco has had with this model impressed the Authority, the Authority noted that San Francisco is one locality with a well established publicly administered hospital and health care clinic system. Connecticut does not have the kind of public health care delivery system that would make this feasible in the near-term.

Universal entitlement to primary care only: This type of plan would allow greater attention to quality and efficiency in the provision of primary care with potentially positive effects on quality and costs. However, the Authority feared that separation of primary and non-primary care could result in disruptions in existing practice patterns and would require a substantial new state administrative burden. The Statewide Primary Care Access Authority is continuing to explore this.

Individual mandate: Over the course of the Authority's deliberation, the issue of individual mandate was discussed. As the Authority nears its conclusion, significant and increased support for individual mandates have gathered in some quarters. Consumer advocates, however, remain rightly concerned that there must be a strengthening of regulatory oversight of insurance policies in terms of benefits and affordability that can be sold to consumers before such a mandate can be responsibly implemented. The arguments for a mandate are strong, and the idea has gained support recently among the insurance community.[25] and is a reality in neighboring Massachusetts. The Authority recommends that serious consideration, based on analysis of data from other states as well as local conditions, be given to the issue of an individual mandate as the health reform process moves forward in Ct. Any consideration of

[25] America's Health Insurance Plans. Health Plans Propose Coverage for Pre-Existing Conditions and Individual Coverage Mandate. Available at http://www.ahip.org/content/pressrelease.aspx?docid=25068.

individual mandate necessitates examination of both affordability and quality/adequacy of coverage and benefit design. In the meantime, implementing the reforms recommended in this report will yield critically important data on the degree of progress made in reducing the ranks of the uninsured, controlling cost, and improving care.

Decision-making on proposed coverage expansions

The Authority commissioned estimates of the costs of the coverage expansions and insurance changes recommended below. Due to circumstances beyond the control of the Authority, these estimates were not received in time to factor into the Authority's deliberations. Therefore, the recommendations outlined below should be taken as the sense of the Authority as to the direction that public coverage expansions, changes to private insurance, and the transformation of care should take. Informed decision-making requires information about costs, so final decisions on the details of the recommendations must await the receipt of cost information in order that the benefits of potential coverage expansions can be traded off against likely costs.

Health reform

Recommendations

Key elements of expansion of coverage and transformation of care

1) Every state resident will have access to health/dental coverage via a health insurance pool with group protections, whether private or public.

2) Every resident with an income below 300% of poverty who cannot access ESI and those who can access ESI but for whom cost-sharing is onerous or the benefits are not available (for example, services for children with special health care needs are not obtainable through ESI plans), will have access to a public (Medicaid or SCHIP) product. Premiums, deductibles, and co-pays will be consistent with generally accepted affordability indices.

3) All insurance coverage paid for in full or in part by the state of Connecticut will incorporate value-based health plan design elements that aim to increase adherence to medically necessary disease treatment plans, increase usage of high value preventive care, reward healthy behaviors and discourage the use of unproven or poor services.. As part of moving in this direction, the Authority encourages the Administration to initiate negotiations with the state employee unions to incorporate these principles into the state plan.

4) Connecticut's approach to universal coverage will build upon the current employer-sponsored healthcare system, allowing those who currently have health coverage that is acceptable and affordable to them to continue with it, and encouraging employers to maintain their current health benefit contributions.

5) Connecticut will maximize federal reimbursement of health care costs for all public health insurance programs, including submission of waivers to the federal government for approval of the current SAGA and Charter Oak programs as Medicaid products.

6) Connecticut will avoid "crowding out" of ESI even as it expands public insurance coverage. It will allow flexibility to subsidize ESI for low-income workers who have access to employer-sponsored insurance but cannot afford the premiums. Such a premium assistance program must be well-designed to take into account whether it is cost-effective for the state, and provides access to quality and affordable health care coverage for the employee, and access to wrap-around benefits provided to Medicaid-eligible enrollees, such as help with paying for transportation to medical appointments.

7) Connecticut's approach recognizes the need to engage the full healthcare community in the care of publicly-insured patients by increasing the Medicaid reimbursement rates to the Medicare Upper Payment Limit.

8) Residents with incomes above 300% of FPL who do not have access to ESI, or who have pre-existing conditions that render other coverage unobtainable or unaffordable represent a specific vulnerable population that must be addressed. While Charter Oak may be the best option for this population, Connecticut must develop a means of subsidizing out-of-pocket expenses for premiums, co pays, and deductibles when those out-of-pocket expenses exceed reasonable affordability levels.

Affordability standard

The Authority recommends that an affordability standard be established that will govern all individual contributions to both public and private coverage. Individuals whose payments reach the established standard will have an opportunity to apply for relief. Affordability is an inherently difficult measure to quantify. One such standard is presented below as an example. Affordability for the state is also a concern. When better information about the resource redistribution implied by these standards is received, a balance will have to be struck between the burden on taxpayers, many of whom would be recipients of the associated subsidies, and the burden on consumers.

Family income as % of the FPL	Medical expenditures as a share of family income
Up to 150%	0
151-200%	1%
201-250%	2%
250-300%	3%
301-350%	4%
350-400%	5%
400-500%	6%

Note: The affordability index presented here warrants further discussion. In particular, it is clear that persons above 500% of the FPL may well face extraordinary out of pocket healthcare expenses and require relief to avoid financial disaster. The AARP, for example, has taken the position that no one should have to spend more than 10% of their income on out of pocket healthcare expenses.

Strategies for coverage expansion

Publicly sponsored plans

In order to accomplish these recommendations, the Authority recommends the following:

Connecticut will submit waivers to CMS requesting:

- Conversion of SAGA to Medicaid
- Conversion of Charter Oak to Medicaid, with upper limit of eligibility at 300% FPL; should also include a buy-in at a state negotiated rate for individuals above 300% of FPL, as is currently done for Husky B
- Expansion of Husky A Parent eligibility to 300% FPL, possibly with premium and co-pay consistent with current HUSKY B levels for parents between 185% and 300% FPL. Note:

currently, pregnant women are covered under Husky A (Medicaid) up to 250% of FP without cost-sharing.

- Family Planning Waiver (in state statute but never implemented)

Support for parents of HUSKY B eligible children

The monthly premiums for Husky B escalates from $30 for one child/$50 for two or more children in families with incomes between 235% FPL and 300% FPL to $200.00 per child per month if family income exceeds 300% FPL. Connecticut will institute a stepped scale to encourage uptake of HUSKY B by parents of uninsured kids.

The Authority recommends no change in the coverage of following enrollees of public programs:

- Traditional Medicaid – Aged, blind, disabled
- HUSKY A parents and pregnant women
- HUSKY A children
- HUSKY B children with family income under 300% FPL

The Authority recommends the following arrangements for individuals and families who would be eligible for new, publicly sponsored assistance, but are expected to pay sliding-scale contributions:

- For eligible residents who are offered employer-based insurance but cannot afford it, the state will develop programs to allow employers to assist their workers to buy into the relevant public program or to allow the state to assist workers in meeting the employee contribution to ESI. In the latter case, the amount of assistance would be equal to what the state would pay if the individual enrolled in a state program (consistent with the affordability principles); in the former, the assistance would equal what the employer contributes for its other employees. Private coverage

The Connecticut Health Partnership (CHP)

The Authority considered the issue of opening the state employees plan to small businesses, non-profits, and individuals. The Legislature has previously considered similar legislation, and is likely to do so again in this session. Advocates of opening the state employees plan, which would be known as the Connecticut Health Partnership, believe this would allow businesses and organizations to join a much larger pool, take advantage of the purchasing power of the state, and help to drive the transformative changes outlined in this report through access to a value based benefit design plan. It has the potential to reduce one of the largest cohorts of the uninsured, those who work in small businesses. New entrant organizations, businesses, or individuals would select both the plan option most affordable and appropriate for them, and establish the percentage of contribution to be made by the employer vs. the employee. To avoid unfair movement of workers at highest risk into this Plan, employers choosing the CHP would offer only the CHP to their employees, who could then choose their preferred plan option within it. Individuals without access to ESI but able to afford one of the plan options provided would have the advantage of joining a large pool.

Opponents of this step have serious reservations that these positive goals can be achieved, and believe there is a real risk of adverse consequences. They note that new plan entrants may drive overall costs

up through potential adverse selection. It may put too much emphasis on a public plan option. Opponents believe there are other options for individuals and small businesses to secure health insurance coverage in Connecticut.

On this subject, the Authority recognizes that there are strongly held views for and against this step. While the co-chairs are in support, they acknowledge and respect the dissenting view of others on the Authority and that there is no consensus opinion.

Section 125 plans
Educate employers and individuals about how Section 125 plans can make health care costs more affordable.

Crowd out and adverse selection provisions
Selection pressures are inevitable wherever people have free choice, so that reform managers need to plan (and budget) for addressing them. Mandates to buy coverage (individual more than employer, which will have major exemptions) require healthy people to share risk with other insureds, but do not protect reform plans from biased selection vis a vis plans that operate under different rules. Income-related subsidizing available only under reform plans and not in the existing market will attract a better mix of risks, but precisely because of the subsidy, the lower risks so attracted will not pay much into the rating pool to offset the costs of older and less healthy enrollees.

Specific countermeasures include allowing only groups and not individuals to buy into reform plans, restricting access to reform plans by requiring a spell of uninsurance, establishing waiting periods for full benefits, and making people sign on for longer terms—but such measures are contrary to the spirit of reform. Another option is to harmonize enrollment and rating rules within and outside the new pools of coverage—which may be seen as contrary to the building-block ideal of letting people who are satisfied with their current plans to stay in them.

From a social perspective, it is desirable to enroll the less healthy into reformed health plans, so that their chronic conditions can be better treated. In order to avoid sinking a reform plan under the weight of high expense enrollees who pay only average (community rated) premiums, there must be an active plan of chronic care management in which the patient's primary care provider plays a critical role as the patient's medical home, and all modes of analysis—evidence based, value based, and experience-based inform treatment decisions. In the long run, effective treatment is the best way to minimize the cost of chronic illness.

The Authority also recognizes and values the services employers, CBIA, and others offer in helping employees of businesses integrate their health insurance coverage with health savings accounts, health reimbursement accounts, on-site employee health services, and other health related programs promoting prevention and wellness initiatives. The innovation these service providers create for those they serve must be sustained. Over time, the Authority would hope that innovations in the Ct. Health Partnership in transformational health care delivery would complement and benefit the private insurance market, and that both the Partnership and the private markets would be laboratories for innovation.

This is a critical area for future study. The health insurance industry has concluded that in order to make affordable coverage available to everyone, then everyone must participate by having some form of health care coverage. Even then, there will be many who still cannot afford that coverage and will need

government subsidies of some sort to enable these individuals to purchase coverage. Further, any reform plan must ensure that people with chronic illnesses will not be singled out, monitored, and possibly excluded from participation.

Enrollment

The Authority recommends changes in enrollment procedures for both public and private coverage based on the belief that individuals have a responsibility for participating in coverage when it is affordable and when it provides both the tools for preventive care and health promotion when they are well, and access to needed treatment to recover health when they are ill. The Authority recommends that Connecticut implement auto enrollment in all public products serving residents earning less than 300% of the FPL at the point of service. As Connecticut's experience clearly documents through the significant numbers of individuals who are eligible but not enrolled in public insurance, merely having eligibility and access is not enough. Individuals who are determined to be eligible for a public insurance program with a premium may opt out with the understanding that penalties may be assessed on re-application, and that such penalties will be consistent with the affordability standard. Employers offering insurance will be required to include opt-out provisions in their offers of employer-sponsored insurance.

Financing

Through these suggested changes, access to affordable ESI will be improved and all individuals earning up to 300% of the federal poverty level who do not have access to affordable ESI should be enrolled in a Medicaid categorical or non-categorical program. Connecticut is further ahead than most states in this regard, and can present a convincing argument to CMS and the federal government that it has a vision and a will to provide universal coverage and access to transformative care for this population. Consistent with the first tenet of financing, maximization of federal funding, the Authority recommends that DSS undertake the following:

- Submit a waiver to CMS that moves SAGA to a Medicaid categorical program, covering childless adults with incomes below 100% of FPL.
- Submit a waiver to CMS that adds HUSKY parents to the S-CHIP program with incomes up to 300% FPL from the current 185% limit, with premiums consistent with HUSKY B levels up to 300% FPL.
- Submit a waiver to CMS that converts Charter Oak Health Plan from a non-Medicaid program to a Medicaid non-categorical program, eligible for a 50 percent reimbursement by CMS, with premiums, co-payments, and benefit package consistent with HUSKY B coverage.
- The State will need to address new revenue sources, based on further data analyses and recommendations of the entity. These analyses must include review of the costs, benefits, and challenges to individual mandate, employer contributions mandate, and taxes on health-negative products
- There is considerable evidence that the State would also see significant savings from implementation of these reforms, such as in the area of preventable admissions to hospital, but these cannot be included "up front" as part of financing as they are potential, not actual sources of financing.

Strategies for care transformation

The HealthFirst Connecticut Authority, as noted above, received a broad legislative charge. It was to determine ways to expand coverage, keep it affordable for individuals and the public, and also to improve the quality of care. Specifically concerning quality, the Authority was explicitly charged with examining and evaluating policy alternatives for ensuring improved quality care, and making recommendations for policy changes to support improved quality of care organized, delivered, received, and paid for in Connecticut. The Authority considered quality, access, and safety, and data management as integral aspects of that charge. Many interventions by the state, often in partnership with private actors, directly address quality concerns. What ties its quality charge together with its other obligations to promote coverage expansion and affordability is the key concept of improving value in health care. Coverage design and operations can often be the mechanism for implementing a vision for quality improvement.

Quality of care is of course important in its own right. Especially important are quality improvements -- including in preventive care or public health measures -- that either reduce the rate of growth in medical spending or are salient enough to increasing willingness to fund them among individuals, their health plans, and public policy makers.

Quality, safety, and access improvements can be incremental or transformational. Some are in the hands of the provider or practice. Policy can encourage and support, but rarely legislate, improvements like the adoption of the chronic care model at the practice level. Moreover, specific changes in coverage and public health policy are often important to facilitate or encourage the kinds of quality-access oriented improvements discussed next. Finally, to be discussed thereafter is the role for improved public data collection, better understanding of problems and the effectiveness of interventions, and more coordinated management of all state activity in health care and financing.

Specific recommendations for improving quality and transforming aspects of care are:

- Support primary care practices in achieving characteristics of a “medical home’ as defined by NCQA
- Allow patients choice to full range of primary care providers, consistent with scope of practice in Ct.
- Increase focus on evidence based care and decision-support tools at point of care; integrate individual preference and experience, clinical expertise, and the most relevant, current, and scientifically sound evidence
- Integrate cultural, language, and health literacy competencies at practice level
- Implement the primary care case management (PCCM) model.
- Develop and implement a strong, community and practice based model of chronic disease management that supports patients and providers.
- Support the implementation of electronic medical records financially and technically
- Develop common performance measure reporting in the ambulatory setting that incorporates process measures, clinical outcome measures, and measures of patient satisfaction
- Support providers, practices, and organizations in implementing electronic health records, electronic communication with patients, and health information exchange (HIE). Support consumers in developing and using personal health records

- Establish and implement evidence based safety standards and reporting at the in-patient level such as the National Quality Forum's Safe Practices for Better Healthcare and AHRQ's Patient Safety Indicators. Monitor Connecticut's progress toward improved safety.
- Develop automatic enrollment of providers into public programs at time of licensure with an opt-out provision.
- Increase provider reimbursement rates under public programs to 100% of Medicare rates
- Create health data infrastructure that drives planning, value design, evaluation, and accountability and provide adequate support for evaluation of monitoring of the system of coverage and financing that is implemented.
- Develop statewide plan with clear criteria for investing in expansion of capacity and new site locations for federally qualified health centers in Ct. Prioritize investment in organizations/sites that meet the practice-based criteria associated with designation as medical homes.
- There is a compelling need for public education throughout the state and its residents on prevention, health care utilization, and self management of health conditions.

Urgency and priority

How do we determine where to put our focus? Some transformations are in the hands of the provider, some in the hands of the consumer, some in the hands of the legislature, and some require significant and complex investment of time, funds, technology, and intellectual capital by a range of stakeholders. As part of the Quality, Access, and Safety workgroup of the Authority, individuals and subgroups with particular expertise were asked to submit recommendations for strategies to address some of these complex areas, including:

- Improvement in chronic disease care coordination and management
- Acceleration in the development and electronic health records and health information exchange
- Construction of a health data infrastructure to enable all state plans to determine what kinds of plan provision changes would be most consistent with value based health plan design principles. Data collection, analysis, and use must drive value-based design and health planning
- Healthcare workforce planning

A copy of the recommendations submitted for each area is found in the Appendix.

Each of these areas will require a dedicated effort to bring about the desired outcomes. The Authority recommends that the next phase of this process provide dedicated support to specific task forces charged with handling these areas. Innovation is a hallmark of each of the proposed approaches.

Containing cost growth to keep coverage affordable

Overall approach to cost containment

It is critical that restructuring of healthcare in Connecticut contain elements that help assure that future growth in health care spending be related to the vision for full coverage, improved care, and better outcomes. The strongest potential for improved performance probably lies in several changes already noted. These relate as much to an enhanced focus on evidence and value within new modes of operation and incentives as to specific policies termed "cost containment." A few examples are noteworthy: Better private and public disease prevention, the assurance of consistent health coverage

over time, and the use of medical homes can do much to reduce the ever-growing burdens of chronic illness. Increasing emphasis on value-driven design of health coverage and benefits can also promote effectiveness and has been shown to slow growth in expenditures. Better informed enrollee choice among competing plans also can achieve improvements over time. This should be coupled with redesign of insurance purchasing practices so as to reduce the rewards of risk segmentation for enrollees and their health plans and reward successful care management on behalf of high-cost enrollees. Allowing patients access to their preferred choice of provider—allopathic, homeopathic, naturopathic, chiropractic physician, as well as nurse practitioners and physician assistants, may contribute to cost savings as well.

Changes in insurance purchasing and operations might also reduce the substantial administrative overheads created by traditional practice, for plans, for providers and for purchasers. Here, harmonizing claims processes across different health plans and between private and public plans could be helpful. This could be achieved through a phased and feasible process that builds upon efforts already under way in the industry and public sector. Properly motivated use of HIT likewise may improve efficiency in terms of both value added and costs incurred. Increases in Medicaid provider payment coupled with longer run incentives for good performance could reduce both the differential between payers' rates that many see as a dysfunctional "cost shift" to the private sector, and the disproportionate use of the ED seen with publicly insured patients.

In sum, many of the strategies discussed above as coverage or quality improvements can also reduce the cost of healthcare. It remains appropriate to present briefly other initiatives that are perceived to focus directly on the cost of health coverage or care.

Policy on "never events"

In March 2002, The National Quality Forum announced a list of 27 "serious reportable events in healthcare" that experts agreed should be publicly tracked as safety indicators. Popularly termed "never events," the listed events included wrong-site surgeries, patient deaths or disability from the use of contaminated drugs or devices, deaths from medication errors, and the discharge of an infant to the wrong family. Subsequently, the listings were adapted for safety tracking purposes in states such as, Minnesota and Pennsylvania. As discussed earlier, the Authority recommends the adoption of NQF's Safe Practices for Better Healthcare and AHRQ's Patient Safety Indicators reporting by hospitals in Connecticut, with a focus on transparency and commitment to continual improvement. "Never events" are currently reported to the Connecticut Department of Public Health (DPH) which reviews all incidents and requires reporting facilities to develop and submit a corrective action plan for each reported event. DPH compiles a summary public report of all reported events each year.

Some private and public policies have gone further. A number of health plans have reduced or eliminated provider payments for some care related to never events, and Maine recently passed legislation that prohibits a hospital (or other facility) from charging a patient or his or her insurer for 28 never events and the treatments needed to correct them. Medicare under the Deficit Reduction Act of 2005 began in October of 2008 to implement denials of payment for the extra care needed to redress "hospital-acquired conditions," an overlapping set of outcomes.[26]

[26] See the CMS website at www.cms.hhs.gov/HospitalAcqCond.

Health plan administrative costs and minimum medical loss ratios

The majority of health plan premium dollars pay for patient care expenses. However, health insurers must also pay for administrative costs that include executive compensation, marketing and advertising, and return on capital or profit. Reducing the amount of non-health care spending could reduce premiums. It has also been pointed out that if health plans are forced to reduce their value added administrative activities such as network contracting, wellness and prevention, disease management, and utilization review activities, health care costs may increase.

Many also favor setting a cap on the percentage of revenue that goes to areas other than patient care. This is known as establishing a *minimum medical loss ratio*.[27] If an insurer does not spend a high enough share of its premium on patient care, then it is required to refund premiums to its enrollees or reduce premiums in the next year. States have set different levels for this medical loss ratio. Five states require that insurance companies spend at least 75% of dollars on patient care for at least some of their policies; recently, some states have proposed legislation as high as 85%.[28] It is notable that loss ratio regulation arose before the era of greater management of care, and this Authority report has recommended even more efforts to improve primary and secondary prevention, many of which likely will not fit within established diagnostic codes for billing purposes. Loss ratios are also difficult to calculate consistently across health plans when those range from fully capitated arrangements to traditional indemnity insurance operations. Over time, administrative costs can be reduced by providing more self-service tools to agents, employers, and plan participants. The development, deployment, and adoption of those tools may require investment by insurance carriers, third party administrators, and insurance agents, along with other investments to improve system-wide productivity. The focus should be on better reporting of the allocation of the total premium dollar to claims payment, health-value added services such as disease management programs, and administrative costs so that consumers and purchasers are to effectively compare plans and benefits.

Health-sector tort liability

The cost of malpractice insurance and "defensive medicine" was raised at many of the workgroup meetings, leading to a session dedicated to exploring only this topic. Comprehensive and consistent data are lacking, but some sources rank Connecticut high nationally in physician liability costs.[29] Independent of the current level of cost, the tendency of malpractice rates to rise rapidly in times of crisis imposes significant strains, especially on office-based practitioners, when health plan payment rates are fixed in advance and grow only slowly. System-wide, the direct cost of providers' medical malpractice coverage only constitutes about 2% of national healthcare spending; the impact of provider defensiveness adds an uncertain additional increment—but underlying assumptions differ across

[27] James C. Robinson, "Use and Abuse of the Medical Loss Ratio To Measure Health Plan Performance," *Health Affairs* 1997 16(4):176-87.

[28] http://familiesusa.org/resources/publications/reports/failing-grades.html

[29] Based on average claims paid on behalf of physicians during 1990-2006, The National Practitioner Data Bank 2006 Annual Report ranks Connecticut 5th from the top among states. http://www.npdb-hipdb.hrsa.gov/pubs/stats/2006_NPDB_Annual_Report.pdf. In its Medical Liability Report Card 2001, NORCAL, a California-based physician-run insurer, ranked Connecticut 7th highest in cost burden per 100,000 population, based on insurer reporting to NAIC used by Best's, along with other sources (unpublished documentation).

estimates, and the limited empirical evidence is inconsistent.[30] Beyond provider liability, health plans and manufacturers of drugs and devices have long said that lawsuits also raise their costs of operation and deter innovation.[31] National policy recognized the harmful effect of traditional product liability for the supply of childhood vaccines—which are the quintessential cost-effective promoter of good health—by creating an alternative federal compensation system in 1986.[32]

Moreover, there is widespread disagreement about the reasons for the high cost and appropriate strategies for reducing the high cost. In particular, most of the discussion about the high cost of medical malpractice insurance does not address one of the greatest problems with our current system: that the vast majority of patients who are harmed as a result of medical care receive no compensation for their injury. Any solution to the costs of medical malpractice must also address this important element.

The Authority recommends at this time that greater emphasis be place on improving safety and the reduction of medical injury and an analysis of other reasons behind the cost of malpractice insurance. Such improvements will directly improve lives and reduce the cost of medical care, and also help control the incidence of claims and ultimately the cost of malpractice insurance.

Consumer protections / insurance mandates, and value-driven benefits design

Connecticut and other states have long required that health insurers include certain medical services or health care providers in their coverages. State rules do not govern self-insured plans, which are exempt under federal ERISA law—and about half of the privately insured are in such plans, as noted above. The federal government has set requirements as well, notably for length of maternity stays and breast reconstruction, which are the only rules applicable in all states and for all health plans.[33] The costs and benefits of these state and federal requirements are controversial, as was apparent when they received frequent mention in the meetings of the Authorities. Nationally, those who emphasize the added costs tend to call them "mandates," while those who see benefits from broader coverage refer to them as "consumer protections." Connecticut ranks high in the number of benefits mandated.[34]

Studies over many years have found varying costs. One July 2008 study in Massachusetts is not atypical, reporting that "12 cents of every $1 paid for health insurance in Massachusetts goes toward 26 state-mandated benefits," according to the Boston Globe. Assessment of benefits is far more difficult, so discussion is imbalanced. Conventional wisdom is that ERISA plans voluntarily cover many or most of

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[30] See discussion and sources cited in Randall R. Bovbjerg and Robert A. Berenson, "Surmounting Myths and Mindsets in Medical Malpractice," Washington, DC: The Urban Institute, Issue Brief, October 27, 2005 accessible at <http://www.urban.org/url.cfm?ID=411227>.

[31] Robert E. Litan and Peter W. Huber, eds, *The Liability Maze: The Impact of Liability Law on Safety and Innovation* Washington, DC: The Brookings Institution, 1991.

[32] National Childhood Vaccine Injury Act of 1986, Title III of Public Law 99-660, codified at 42 U.S. Code, Sect. 300aa-1 and following.

[33] Laugesen MJ, Paul RR, Luft HS, Aubry W, Ganiats TG. A comparative analysis of mandated benefit laws, 1949-2002. *Health Serv Res*. 2006 Jun; 41(3 Pt 2):1081-103.

[34] See US GAO, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, US Government Accountability Office, report no. GAO/HEHS-96-161, August 1996, http://www.gao.gov/archive/1996/he96161.pdf. The annual Blue Cross and Blue Shield Association report on *State Legislative Health Care and Insurance Issues: Survey of Plans* also lists mandated benefits for each state. The reports are not posted online; for a very short summary of 2009 report, see http://www.bcbs.com/news/bcbsa/state-healthcare-initiatives-focus-on-expanding-coverage.html.

these benefits under most clinical circumstances, but not on the non-discretionary, sometimes open-ended basis of formal legal requirements.

Usage of pharmaceuticals and evidence-driven prescribing

Prescription drug spending is high and has been rising faster than the rest of health care for some years. However, drugs make great contributions to health care—both by improving outcomes and by reducing hospitalization and other spending in health care. Much of pharmaceutical policy, including the large share of the market accounted for by Medicare and Medicaid, is governed by federal decisions. The key policy over which Connecticut can exert constructive influence is promoting appropriate usage of drugs within existing and expanded health insurance coverage. Providers may overprescribe for a variety of reasons, and consumers may seek out inappropriate prescriptions or fall short of completing an appropriate regimen, again for many reasons.

These are complex issues, but in brief the ideal in each case is to move behavior in the direction of evidence-driven usage of pharmaceuticals, so as to optimize the great benefits that drugs contribute in health care. A priority should be to make good information more accessible and to make benefits design and payment incentives increasingly value-related over time so that practitioners and patients will act on that good information. Greater use of therapeutically equivalent generic drugs is a good example, an existing trend that ought to be continued. To the extent that authoritative new information could reduce the relevance of the very high marketing expenses built into pharmaceutical costs, that could be a benefit as well; here, both state and federal policy are implicated. Pharmaceutical coverage and benefit practices are, like others already discussed, a matter for continual evidence-based assessment and improvement on the part of health plans and the employers and public agencies that contract with health plans.

It is the sense of the Authority that several interventions may be appropriate, depending upon more detailed weighing of their effectiveness. Most are public health interventions, but they should also be harmonized with any overlapping federal and private efforts.

- *Establish an academic detailing program*. These programs, which exist in many other New England states,[35] educate providers on evidence-based guidelines and indications for medications. They have been shown to save the Medicaid programs in these states money, but might constructively be created in conjunction with private health plans.
- *Make more transparent or ban financial or in-kind support or gifts from pharmaceutical and device companies to providers*. Failure to disclose research support has already received substantial attention within the research and publishing communities. Gift giving and free lunches appear to be on the decline, but should not continue. Industry practices should follow the principles set forth in the Federal Department of Health and Human Services Office of Inspector General Compliance Program Guide, which sets ethical guidelines around interactions between physicians and pharmaceutical industry representatives.
- *Wean providers from industry-funded Continuing Medical Education (CME). Industry pays for much of the CME that provider*s are required to obtain as part of maintaining their license,

[35] PA, VT, MA, NH, SC, ME, NY. Prescription Policy Choices is working to coordinate efforts between VT, NH and ME, and the MA legislation instructed the state to work with VT and NH on its new program.

resulting in potential conflicts of interest. The Authorities recommend that providers rely more on CME that is not paid for by industry and effective alternatives be identified and implemented.

- *Learn from the VA.* While formularies are often unpopular, the experience of the V.A., where physicians build the formulary based on clinical evidence, is instructive and worth considering. Efficient and accessible systems of prior authorization, with temporary supplies of such medications provided, are a component of a rational drug formulary program.

Public role in private provision of care

A number of broad rationales justify public actions to improve the value of health care delivered and received in Connecticut: The state plays many roles in the purchase of health coverage and hence in the care to which they provide access. The state not only pays for public health insurances, but also helps state and local employees buy private coverage. The state also provides tax subsidies for ESI purchase. The purpose of health insurance, as it now operates, is to provide prepaid access to valuable health care services. Purchasers have a natural interest in getting good value for their money, and in the case of Medicaid, state regulators also fulfill federal obligations for quality assurance. The state traditionally oversees the quality of both health delivery and health insurance. These are regulatory powers of long standing; licensure regimes for practitioners and institutions that deliver care have been evolving for over a century, and insurance regulation is almost as old. The state has a responsibility for the health and welfare of its residents. States have long acted to improve public safety and welfare in innumerable ways, which is the most fundamental function of government. Many types of direct population-health interventions and regulation of public safety and the environment are thereby justified.

Implementation

In making its recommendations, the Authority is mindful of current economic conditions in the state and in the nation. The Authority believes that the changes in the health care system that it is recommending will result in savings to the system in the medium and long term. However, many of these changes will cost money in the short run. The significant change in economic circumstances since the time the Authority was constituted means that implementation of any recommendations that entail new expenditure of public funds is likely to be delayed. The Authority is also mindful of the change in administration at the federal level and the likelihood of significant policy changes in the area of healthcare. Finally, the Authority recognizes that decisions made about entitlement programs, such as broadening eligibility, have implications for the state budget over the long term.

In spite of these current uncertainties, the Authority believes that the state should move forward on its recommendations for two reasons. First, the state needs to be ready to implement these much-needed changes to coverage and health care delivery when the economy improves. Changes that do not involve state expenditures or for which alternative financing can be found should be implemented as soon as possible. Second, the changes at the federal level are likely to present new opportunities for state-federal cooperation on health care reform. Some of the recommendations can be implemented in pilot form or on a demonstration basis. The state needs to be “shovel-ready” when new opportunities are presented.

The recommendations propose a broad strategy rather than a detailed plan. As noted above, final decisions on details of the recommendations are deferred due to a delay in getting estimates on the likely costs of the various proposals. Furthermore, current costs estimates cannot take into account the effects of the current economic downturn on the health care system, on the number of uninsured, or on changes in health care coverage, both in terms of coverage level and benefits.

Therefore, the Authority has agreed in principle to the following components of coverage expansion:

- All citizens with family incomes under 300% of the FPL will be given access to a Medicaid plan.
- All residents will have access to a new Charter Oak program, with family financial contribution linked to an affordability standard.
- The state will make an insurance partnership available to all residents and all employers to improve employer offer rates and employee take-up rates, and to create access to affordable coverage for residents in the non-group market.

Opening access to public coverage programs without improving physician participation in these programs is likely to lead to bottlenecks in access to care. Similarly, increasing the share of the population covered by public programs without addressing provider costs could exacerbate cost-shifting. Expanded access to public programs and to coverage in the Partnership will require careful design as well as changes in insurance regulation to minimize adverse selection and crowd-out. It is recommended that changes in the health care delivery system and in insurance regulation be made in concert with these coverage expansions in order to make coverage more affordable for individuals and to make the necessary subsidies affordable for the state over time.

Responsibility for health reform

Functions

Health reform, which encompasses both coverage expansion and care transformation, has four critical functions: data collection and analysis, policy development based on the analyses, implementation of programs that support these policies, and monitoring and evaluation of the effects of the implemented programs.

Expansion of coverage, transformation of the health care system, and monitoring of progress in delivery, in health outcomes, and in reduction of disparities all require information. As a first step toward coverage expansion and care transformation, the Authority recommends an inventory of data sources and identification of data gaps. In the short run, information needs can likely be largely met using available data such as the Medicaid data, hospital discharge and ED data, and FQHC records. In the long run, the state needs to collection of data to fill identified data gaps a priority. Timely data analysis will allow informed policy development and a focus on value-based health coverage benefit design and health care delivery and support for evidence-based medicine. Policy and implementation should take maximum advantage of federal reform efforts and new financing opportunities.

Implementation and program monitoring and evaluation go hand in hand, with processes for evaluation built into each initiative from the beginning. Ongoing data collection and analysis will provide the information to judge how well each initiative is achieving its objectives. Responsiveness to the flow of information and flexibility to make mid-course corrections, as called for, will be key to achieving value.

Recommended characteristics of responsible entity

The Authority discussed where responsibility for implementing health reform should be placed. While no agreement was reached on an implementing entity, the Authority did agree on the characteristics that such an entity should have. The changes that are envisioned require a long-run view of investment in health and a clear understanding of the long-term implications of decisions for the state budget. Justification of decisions should rest on the concept of getting the best overall value for expenditures of state funds. The independence and freedom will help provide the entity with the flexibility to respond as needed to data and so be better placed to achieve the goal of value-driven design. These characteristics can be built into the structure of the entity. Willingness to try new approaches, openness to innovation, risk-taking, and a willingness to make corrections on the way to succeeding must be combined with strong analytical abilities to help guide Connecticut to a new, more efficient and more equitable health care system.

Options

The Authority recommends that a public entity be assigned or developed to oversee these reforms and to better coordinate state spending on health care. Over time it may make sense for this entity to be transformed into an independent body for greater flexibility, but that decision can come at a later date.

The entity should be guided by a five person board appointed by the Governor and legislative leaders. Appointees and staff need to be free of conflict of interests. The Comptroller, the Commissioner of Social Services, the Commissioner of Public Health, the Commissioner of the Office of Health Care Access, the Health Care Advocate, the Secretary of OPM, and the Executive Director of CHEFA should serve as non-voting ex-officio members. In addition, each of these agencies should have reporting duties to the entity.

Initial staffing should come for the most part from existing resources. The entity shall be empowered to call on existing agencies or to create workgroups that can engage people with expertise to tackle particular areas of interest. Initial priorities would include: Data, Workforce Development and Scope of Practice, Health Information Technology, Improving Chronic Illness Care, and Evidenced Based Guidelines. A key function of the entity will be the development of recommendations for the Legislature and the Governor on the implementation of health reforms, including financing of reform.

Among the critical issues to be considered are adverse selection, crowd out, individual mandates, employer contributions, and other data dependent issues for which the Authority had insufficient evidence and data to render final recommendations.

Summary and Conclusion

The Authority considered a wide range of evidence and points of view. It recommends a phased implementation of its recommendations with Phase 1 devoted to establishing the structure for data collection and planning, securing maximum federal contribution and reimbursement to Connecticut, and driving elements of care transformation identified in this report and guiding the implementation of any new federal health reforms. It identified a pressing need for both expanded coverage and transformation of the system of care. It strongly believes that expanded coverage alone will not solve the problems in Connecticut's health care system, for either individuals or providers. Throwing money at the problem is not an answer because the long-run costs of business as usual are unsustainable. Implementing data-driven, value-based coverage and care offers the opportunity to control system costs so that more residents can have adequate coverage and so that providers can be relieved of the burden of uncompensated care and a mismatch between revenues and costs.

The recommendations in this report are designed to provide individuals and providers as well as employers and the state with the incentives for a more efficient and smarter system of care, particularly as it relates to the growing problem of chronic disease care and coordination. Broader coverage will also allow a reduction in disparities in health care and health outcomes. Providers will have incentives to help individuals manage their own care and take responsibility for appropriate preventive behavior. Responsibility for financing health reform will be based on a maximization of federal revenues and an equitable distribution of the remaining costs among individuals, employers, and the state.

In this report, the Authority has laid out principles and strategies for achieving universal coverage as well indicated possible mechanisms for implementing these recommendations. Final decisions on the details of the proposed initiatives must await further information on their costs, a better understanding of the dimensions of the current economic crisis, as well as developments at the federal level. The Authority recommends that these decisions be made by the implementing entity.

Appendix 1 – Membership

HealthFirst Connecticut Authority Membership

- David Benfer
- Michael J. Critelli
- Michael Fedele, Lt. Governor
- Margaret Flinter
- Brian Grissler
- Mickey Herbert
- Sharon Langer
- Sal Luciano
- Tom Swan
- Lenny Winkler

- Fernando Betancourt, Executive Director (Ex Officio-Nonvoting)
- Glenn Cassis (Ex Officio-Nonvoting)
- J. Robert Galvin, Commissioner (Ex Officio-Nonvoting)
- Kevin Lembo, Healthcare Advocate (Ex Officio-Nonvoting)
- Michael P. Starkowski, Commissioner (Ex Officio-Nonvoting)
- Thomas R. Sullivan, Commissioner (Ex Officio-Nonvoting
- Nancy Wyman, Comptroller (Ex Officio-Nonvoting)
- Teresa Younger, Executive Director (Ex Officio-Nonvoting)

State-Wide Primary Care Access Authority Membership

- Daren Anderson, MD
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- Sandra Carbonari, MD
- JoAnn Eaccarino, APRN
- Margaret Flinter, APRN
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- Lynn Price, APRN
- Jody L. Rowell
- Bob Schreibman, DMD
- Tom Swan
- Frank Sykes
- Teresa Younger
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- Robert Galvin, MD (Ex Officio-Nonvoting)
- Michael P. Starkowski (Ex Officio-Nonvoting)

HealthFirst Connecticut Authority
Cost, Cost Containment and Finance Workgroup Membership

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- Ellen Andrews
- Al Ayers
- Evelyn Barnum
- David Benfer
- Fernando Betaneourt
- Randy Bovbjerg
- Lou Brady
- Beverley Brakeman
- Rob Caione
- Leo Canty
- Tanya Court
- John Dobson
- John Farrell
- Paul Filson
- Margaret Flinter
- Stephen Frayne
- Eric George
- Andrew Gold
- Adele Gordon
- Paul Grady
- Jerry Hardison
- John Harrity
- Mickey Herbert
- Sanford Herman
- Yvette Highsmith-Francis
- Michael Hudson
- Karl Ideman
- Eli Henry Jacobs
- Alexis Kozmon
- Ned Lamont
- Sharon Langer
- David Landsberg
- Paul Lombardo
- Lina Lorenzi
- Sal Luciano
- Bob Madore
- Natalie Morris
- Patricia Nazemetz
- John O'Connell, Jr.
- Barbara Ormond
- Joseph Pavano
- Sue Peters
- John Rathgeber
- Connie Razza
- Gray Rich
- Bob Rinker
- Alyssa Rose
- Dr. Rexford Santerre
- Lud Spinelli
- Gary Spinner
- Judith Stein, Esq.
- Jamie Stirling
- Mark Sudock
- Tom Swan
- Art Tanner
- Sheldon Toubman
- Robert Tessier
- Victoria Veltri
- Joseph Walton
- Jill Zorn

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- Debra Anastasio
- Daren Anderson, MD
- Kirsten Anderson, MD
- Richard Antonelli, MD
- Pat Baker
- Jamey Bell
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- Linda Berger-Spivak, RN
- Mark C. Borton
- Dr. Peter Bowers, MD
- Kathleen Brandt, RN
- Angelo Carrabba, MD
- Shanti Carter
- Dan Cave
- Deborah Chernoff
- Katrina Clark
- Tanya Court
- William Cox
- Lisa Davis, RN
- John Erlingheuser
- Matt Fair
- Brian Fillipo, MD
- Margaret Flinter, APRN
- Wendy Furniss, RN
- Davis Gammon, MD
- Frank Gerratana, MD
- Bruce Gould, MD
- Shawn Grunwald
- Jennifer Jackson
- Jennifer Jaff
- Betty Jenkins-Donahue, RN
- Lisabeth Johnston, APRN
- Steve Karp, LCSW
- Martin Kodish, MD
- Greg Kotecki
- Joan Lane
- Sue Lanza
- Mary Alice Lee
- Estela Lopez
- Lina Lorenzi
- Alejandro Melendez-Cooper
- Jane Nadel
- Matt Pagano, D.C.
- David Parrella
- Bob Patricelli
- Brent Pawlecki, MD
- Marcia Petrillo
- Jim Rawlings
- Jean Rexford
- Lisa Reynolds
- Rodney Sappington
- Bob Scalettar, MD
- Arvind Shaw
- Richard Sivel
- Maureen Smith, MS, RN
- C. Todd Staub, MD
- Judith Stein
- Tom Swan
- Mary Jane Toomey
- Joe Treadwell
- Victor Villagra, MD
- Lenny Winkler, LPN
- Teresa Younger
- Kristen Zarfos, MD
- Robert Zavoski, MD

Appendix 2 – Meetings and Presentation

HealthFirst Connecticut Authority Meetings and Presentations:

12/08/08 - Updated Outline for Discussion

10/23/08

Randy Bovbjerg, Barbara Ormond – Kansas Health Policy Authority:
http://cgalites/ph/HealthFirst/Docs/KS.Hlth.Pol.Auth.RRB.presentation.23Oct08_provisional.ppt

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9/11/08

Martha Judd – Report on the Healthy San Francisco Model
http://cgalites/ph/HealthFirst/Docs/091108/HEALTHFIRST SAN FRANCISCO.pdf

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7/16/08

Mike Critelli – Pitney Bowes – Value Based healthcare:
http://cgalites/ph/HealthFirst/Docs/value based health care plan design white paper.pdf

Commissioner Michael Starkowski, David Parella – Charter Oak Plan
http://cgalites/ph/HealthFirst/Docs/MMCC HUSKY_Charter Oak Update0711.ppt

Sharon Langer – Connecticut Voices for Children – Medicaid:
http://cgalites/ph/HealthFirst/Docs/Health First Advisory Slides.ppt

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6/19/08 - Discussion Draft for Final Report

5/29/08 - Building Blocks for Advancing Universal Coverage, Cross Cutting Issues

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5/1/08

Discussion Notes:
http://cgalites/ph/HealthFirst/MeetingSummaries/HFirstCT_discussion_notes050108.pdf

Expansion Options:
http://cgalites/ph/HealthFirst/RM/ExpansionOptions Discussion for May 1.pdf

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4/3/08

Randy Bovbjerg, Barbara Ormond – Urban Institute:
http://cgalites/ph/HealthFirst/Docs/Guiding%20Principles%20for%20CT%20Health%20Reform_HFCT.ppt

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3/4/08

Andrew Gold – Pitney Bowes:
http://cgalites/ph/HealthFirst/Docs/HealthFirst%20Authority.ppt

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2/20/08 – Timeline for the HealthFirst Authority

1/16/08

Stan Dorn – Urban Institute:
http://cgalites/ph/HealthFirst/Docs/A_Summary_of_Health_Policy_Work.ppt

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12/12/07

Mark T. Bertolini - Aetna – proposals for healthcare reform:
http://cgalites/ph/HealthFirst/Docs/Aetna 10pt Plan.pdf

Robert Patricelli – Connecticut Health Insurance Policy Council:
http://cgalites/ph/HealthFirst/Docs/Health First Commission January 2007 Correct Copy.ppt
11/14/07 - Institute Of Medicine Principals

10/17/07 – Introductory meeting

State-Wide Primary Care Access Authority Meetings and Presentations:

11/26/08

Darren Anderson – VA Transformation of Primary Care Services: *http://cgalites/ph/PrimaryCare/Docs/VA Connecticut Healthcare System.ppt*

10/29/08

Todd Staub, Jim Cox-Chapman – Transforming Primary Care *http://cgalites/ph/PrimaryCare/Docs/TransformingPrimaryCareFinal.pdf*

9/17/08 – Uconn – Assessment of Primary Care Capacity in Connecticut

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8/12/08

Brian L. Benson – The University Of Connecticut Health Center – Economic Impact of Prevention: *http://cgalites/ph/PrimaryCare/Docs/UCONN_EconomicImpactPrevention.pdf*

6/19/08

Office Of Health Care Access – Preventable Hospitalizations: *http://cgalites/ph/PrimaryCare/Docs/Primary Care Access Authority608_V2.ppt*

5/14/08

Mitch Katz – Healthy San Francisco Model: *http://cgalites/ph/PrimaryCare/Docs/Healthy San Francisco_Mitch Katz.ppt*

Randy Bovbjerg - ERISA *http://cgalites/ph/PrimaryCare/Docs/ERISA.considerations.in.CT.hlth.reform.14may08.RRB.rev'd.ppt*

4/3/08

Steven E. Wegner – Community Care of North Carolina:

http://cgalites/ph/PrimaryCare/Docs/April 3 - Urban Institute_FINAL.ppt

Randy Bovbjerg, Barbara Ormond – Urban Institute:
http://cgalites/ph/PrimaryCare/Docs/Guiding%20Principles%20for%20CT%20Health%20Reform_SPCAA.ppt

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2/27/08

Connecticut Community Providers Association:
http://cgalites/ph/PrimaryCare/Docs/CCPA primary care access presentation 2-27-08.pdf

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1/23/08

David Parella – Director, Medicaid Program, DSS:
http://cgalites/ph/PrimaryCare/Docs/Update%20on%20the%20Husky%20Transition.managed%20care%20council.ppt

Commissioner Cristine Vogel – Office of Health Care Access

12/19/07 – Primary Care Inventory: Goals, Strategy, and Specifics

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11/21/07 – Development of Workgroup and Progress Report

10/24/07 – Introductory meeting

Quality, Access and Safety Workgroup Meetings and Presentations:

10/30/08 – Report on Public Hearings and Preliminary Findings and Recommendations of the HealthFirst Authority

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7/30/08

Victor Villagra – Chronic Care Management
http://cgalites/ph/HealthFirst/QAS/Disease%20Management-%20Dr.%20Villagra-Session%202.ppt

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6/18/08 – Recommendations of Cross Cutting Issues

5/8/08

James Rawlings – NAACP – Health Status Report of African Americans in Connecticut:
http://cgalites/ph/HealthFirst/QAS/naacp-aahsreport(5-08).ppt

Hispanic Health Council – Latino Health in Connecticut:
http://cgalites/ph/HealthFirst/QAS/LPI presentation.ppt

4/10/08

Richard Antonelli – Medical Home Model:
http://cgalites/ph/HealthFirst/QAS/Medical Home in CT Health First CT 04 08.ppt

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3/6/08

Victor Villagra – Disease Management:
http://cgalites/ph/HealthFirst/QAS/Disease Management- Dr. Villagra.ppt

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1/31/08 – Introductory Meeting

Cost, Cost Containment and Finance Workgroup Meetings and Presentations:

10/22/08

Connecticut Insurance Department – Current Business Environment:
http://cgalites/ph/HealthFirst/CCF/Connecticut Insurance Department 10-22-08_2.1.ppt

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9/25/08

Office of the Healthcare Advocate – Consumer Protections Under State and Federal Law:
http://cgalites/ph/HealthFirst/CCF/CCF Consumer Protections 9-25-08.ppt

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7/29/08

Major Health Expenditures:
http://cgalites/ph/HealthFirst/CCF/Major Health Costs july 3 2008.xls

AHIP Center For Policy and Research:
http://cgalites/ph/HealthFirst/CCF/Connecticut Health Reform Study Group -- July 2008.ppt

Connecticut Hospital Association – Demand, Input and Inadequate Funding:
http://cgalites/ph/HealthFirst/CCF/072908 Presentation on Cost Drivers (white).pdf

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5/9/08

John Farrell – Availability and Use of Health Care Data
http://cgalites/ph/HealthFirst/CCF/healthfirst ct authority 5-9-08.ppt

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4/11/08 – Cost Containment Discussion

1/22/08 – Introductory Meeting, Discussion of Charge

Appendix 3 – Articles, Reports & Documents Reviewed

Articles, Reports & Documents Reviewed

- **Jaff, Jennifer, C**. *The Role of Patients in Chronic Care Management*. Advocacy for Patients with Chronic Illnesses, Inc. Farmington, CT. 2008.

- **Critelli, Michael**. Value-Based Health Care. 2008.

- **Holt, Wexler & Farnam**, LLP. One Coast, One Future. *Health Care Workforce Initiative*. 2007.

- **Connecticut State Conference of NAACP Branches Health Committee**. *A Health Status Report on African American in Connecticut*. 2007.

- **Connecticut Voices for Children**. *Census data show decline in CT uninsured but no progress in reducing poverty despite economic growth*. 2008.

- Health San Francisco Model for HealthFirst CT Authority

- **The Center for Public Health and Health Policy** at the University of Connecticut Health Center, Storrs, CT. *The Economic Impact of Prevention*. 2008.

- **America's Health Insurance Plan (AHIP).** *A Shared Responsibility: Advancing toward a more accessible, safe and affordable health care system for America*.

- **Pronovost, Peter J., MD, PhD et al.** *The Wisdom and Justice of Not Paying for "Preventable Complications*". JAMA, 299 (18): 2197-2199. 2008.

- **Wilson, Jennifer Fisher.** *Vermont Health Care Reform Aims for More Coverage, Less Expense and Better Car,* Current Clinical Issues**.** Annals of Internal Medicine, Vol. 148, (10)797- 800, 2008.

- **The Connecticut Permanent Commission on the Status of Women and the Foundation for CT Women by the Women's Union.** *The Real Cost of Living and Getting Healthcare in Connecticut: The Health Economic Sufficiency Standard*. Permanent Commission on the Status of Women Report. December, 2008.

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- **Baucus, Max**, US. Senator. Call to Action. Health Reform 2009. *Reforming American's Health Care System: A Call to Action*. November, 2008.

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- **Keiser Commission**. *Healthy San Francisco*. Medicaid and the Uninsured. March, 2008.

- **Butler, Patricia, A.** *ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision.* National Academy for State Health Policy. 1-13. November, 2006.

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- **Fein, Rashi,** PhD**.** Universal Health Insurance – Let the Debate Resume. JAMA, 290: 818-820. 2003.

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- **Lischko, Amy**. *State Coverage Initiatives. Health Insurance Connectors & Exchanges: A Primer for State Officials*. Academy Health. September 2007.

- **Holahan, John; Blumberg, Linda J**. *Do Individual Mandates Matter? Timely Analysis of Immediate Health Policy Issues.* Urban Institute. January 2008.

- **Newton, Warren P.; DuBard, Annette; Wroth, Thomas H**. New Developments in Primary Care Practice. NC Medical Journal, Vol. 66, 3: 194-204. May/June 2005.

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- **Miller, Robert H et al**. *The Value of Electronic Health Records in Solo or Small Group Practices.* Health Affairs, September/October 2005.

- **Katz**, **Mitchell H**. *Golden Gate to Health Care for All? San Francisco's New Universal-Access Program.* New England Journal of Medicine. 327-329. January 2008.

- **Bodenheimer, Thomas**. *High and Rising Health Care Costs. Part 1: Seeking an Explanation.* Annals of Internal Medicine. 142: 847-854. 2005.

- **Bodenheimer, Thomas**. *High and Rising Health Care Costs. Part 2: Technological Innovation.* Annals of Internal Medicine. 142: 932-937. 2005.

- **Bodenheimer, Thomas**. *High and Rising Health Care Costs. Part 3: The Role of Health Care Providers.* Annals of Internal Medicine. 142: 996-1002. 2005.

- **Bodenheimer, Thomas; Fernandez, Alicia**. *High and Rising Health Care Costs. Part 4: Can Costs Be Controlled While Preserving Quality?* Annals of Internal Medicine. 143: 26-31. 2005.

- **Bodenheimer, Thomas; Berenson, Robert A.; Rudolf, Paul**. *The Primary Care- Specialty Income Gap: Why it Matters*. Annals of Internal Medicine. 146: 301-306.

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- **Frieden, Thomas; Mostashari, Farzad**. *Health Care as if Health Mattered*. JAMA, Vol. 299, 8: 950-951. February 2008.

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Appendix 4 – Strategy for Caring for Connecticut's Chronically Ill

Caring for Connecticut's Chronically Ill: A Community-based Public Utility Model

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Context

In the last 10 years two distinct models of chronic care emerged. One, "disease management" (DM) developed in close association with payers, especially managed care. The other, "the chronic care model" (CCM) emerged from within the outpatient delivery system. Both acknowledged the lack of a suitable infrastructure to care for people with chronic conditions. Both systems recognized that one or more chronic conditions impose a significant burden of self-care on individuals, and that to achieve optimal outcomes active patient participation is essential. Each model proposed a new infrastructure to support doctors and patients at the point of care and "between visits". Both models sought improvements in quality and better outcomes but DM also focused on reducing costs whereas the CCM emphasized delivery system redesign while remaining more circumspect about its impact on cost. For several years, public and private entities sponsored experiments and demonstration projects using one ***or*** the other model. Attempts to link them in a coordinated fashion have proven extremely difficult. The introduction of novel and effective (lower cost, higher quality, high user satisfaction) approaches to chronic care could also secure new revenues to the sponsoring organization. An unspoken, stubborn competition for control and "ownership" of the chronic care domain fueled an unproductive provider-payer divide that deprived everyone, but especially patients of the considerable benefit of collaboration.

Where does chronic care stand today?

The DM movement is at a crossroads and needs major improvements. The model developed an operational infrastructure based on remote support (mail, telephone and internet). It also developed sophisticated analytical tools to harness information from administrative data to understand care patterns and to drive proactive preventive interventions. DM interventions to patient promote lifestyle changes, adherence to drug regimens, performing regular self-monitoring and so on. Interventions directed to physician such as mailing lists of patients not receiving recommended medications or tests (e.g. ACE inhibitors in heart failure patients or eye exams for diabetics respectively) have been fraught with inaccuracies and devoid of context so that recommendations for action are rarely heeded by physicians.

The chronic care model also gained momentum, more recently under the banner of the "Medical Home" movement. A well organized coalition of primary care organizations has fully embraced the concept, and the endorsement is paying off. In 2006 Congress authorized funding for several Medical Home demonstration projects and private foundations, employers and commercial payers appear interested in following suit giving the initiative great momentum.

DM and the CCM have contributed significant conceptual, operational, analytical and technological advances towards the care of chronically ill people; payers and providers each in their own unique ways, leveraging their respective assets. Regretfully these efforts could not escape the gravitational force of the often bitterly antagonistic payer-provider relations negating everyone, but principally patients, the potentially enormous benefits of collaboration. As we explore new ways to implement health reforms in Connecticut we must find ways to abolish unproductive posturing and take advantage of the myriad lessons so painstakingly learned from BOTH the CCM and DM models over the last decade.

Fortunately there are abundant signals that physician practices are recognizing the need for a more pro-active, data-driven and technologically sophisticated approach to chronic care that expands beyond the confines of the office setting. At the same time DM programs are also realizing that they must engage patients "on the ground", rely more on in-person interactions and not just on remote care protocols. Above all DM programs must coordinate operations with physicians. Both approaches are needed because they are complementary and neither model can fully emulate the other. Finally and perhaps most importantly health reform policies that meaningfully places patient as the epicenter of all efforts could leapfrog us forward with the legitimacy and vigor commensurate with the opportunity at hand.

Where should we go from here?

The proposed new system for chronic care ("the third way") must leverage all successful features of existing models. It must also eliminate residual ballast and decidedly break away from the "payer-vs.-provider control" gridlock. Moreover, it must introduce patients- activated, educated, empowered with information- and place them as the main beneficiaries of the new system. This vision can be accomplished by the introduction of a new independent entity modeled after public utilities not unlike water, electricity or public education: a new "community-based health care utility" initially devoted to support care for the chronically ill and later expanded to cover other domains of the health continuum (ie: wellness and prevention). The basic organization of this system include the following features

- A new public-private entity ("CT Care Coordination Centers [C^4]) devoted to the provision of remote AND community based (in-person) support to chronically ill people and their physicians.
- Neither payers not providers will have ownership or control over C^4s. The ownership structure will resemble public utilities under the jurisdiction of the State of Connecticut Department of Public Utility Control.
- C^4s will exceed all the requirements for NCQA or CMS "medical home" status when associated with a primary care physician practice.
- All subscribers with one of more chronic conditions whose providers subscribe to C^4 are eligible to receive services, free of charge.
- C^4s will provide at least the following services
    - Case management
    - Disease management (includes secondary and tertiary prevention)

- Care coordination
- Data analysis and public outcomes reporting (cost, quality, patient and provider satisfaction)

- C^4 will be initially a single site pilot. Subsequently it will expand throughout the state and service beneficiaries and providers in well defined geographic areas.

- Physician practices that do not meet NCQA or CMS requirements for "medical home" status (any level) [and therefore not qualify for additional payments] can subscribe to their local C^4 and become automatically eligible to receive top level "medical home" payments immediately, thus avoiding significant capital layout. The subscription must be for a minimum time period (TBD) and can be renewed or let lapse upon expiration of the subscription contract.[36]

- Private payers under contract with the state must subscribe to the C^4 utility. Subscription entitles payers' members to C^4 services, and to reports on their sub-set of subscribers.

- C^4s centers will be interconnected and operate in coordinated fashion with each other throughout the state.

- Participating providers must submit regularly a "minimum clinical data set" and participating payers a "minimum administrative data set" to support population health interventions, reporting of cost and quality outcomes and other C^4 functions. Patients will be asked to fill-out and maintain (annually) a well validated Health Risk Assessment and a Quality of Life/Functional Status assessment.

Unique advantages of a Community-based Health Utility model

1. A public utility acknowledges that the service is a basic societal need that the state must address on behalf of its citizens.

2. A public utility operates within certain boundaries which strive to balance the public good with private interests.

3. Avoidance or mitigation of any real or apparent public perception of conflict of interest when medical and financial functions coexist within the same organization. The Community-based Health Utility should function with a technocratic mind set. This means evidence-based medical protocols and data-driven process management.

4. A public utility need not be operated by the state. Considerable expertise exists in the private sector to supply technology, management, clinical contents and informatics to the new entity.

5. Subscription to C^4 is entirely voluntary on the part of physicians (but mandatory to state-sponsored payer organizations). Such a system is not coercive but incentive-based. It affords physicians in small practices the same opportunities as large practices to avail themselves of care

[36] A physician practice that becomes "medical home" self-sufficient can offer coordination services and keep 100% of the medical home revenues.

coordination capabilities and therefore realize additional revenues from Medical Home sponsoring sources.

6. From the system re-design perspective, installing a community-based utility is considerably more efficient (economies of scale, standardization, access to capital, deployment of information technology, etc.) than a practice-by-practice duplication of similar capabilities.

7. Harmonization of process and outcome measures, inter-physician communication and care coordination across settings (in-patient → out-patient) in an industry fraught with silos and one-offs.

Some expected benefits of the proposed system

1. Mitigation of "crowding out" effect of universal coverage by the provision of high quality, physician directed support services in the community, at home or at work rather than exclusively in the doctor's office.

2. Decompression of emergency room visits for minor (but often worrisome symptoms to patients) problems.

3. Lower use of emergency room and hospital beds related to poor patient adherence to simple but highly effective self-care routines.

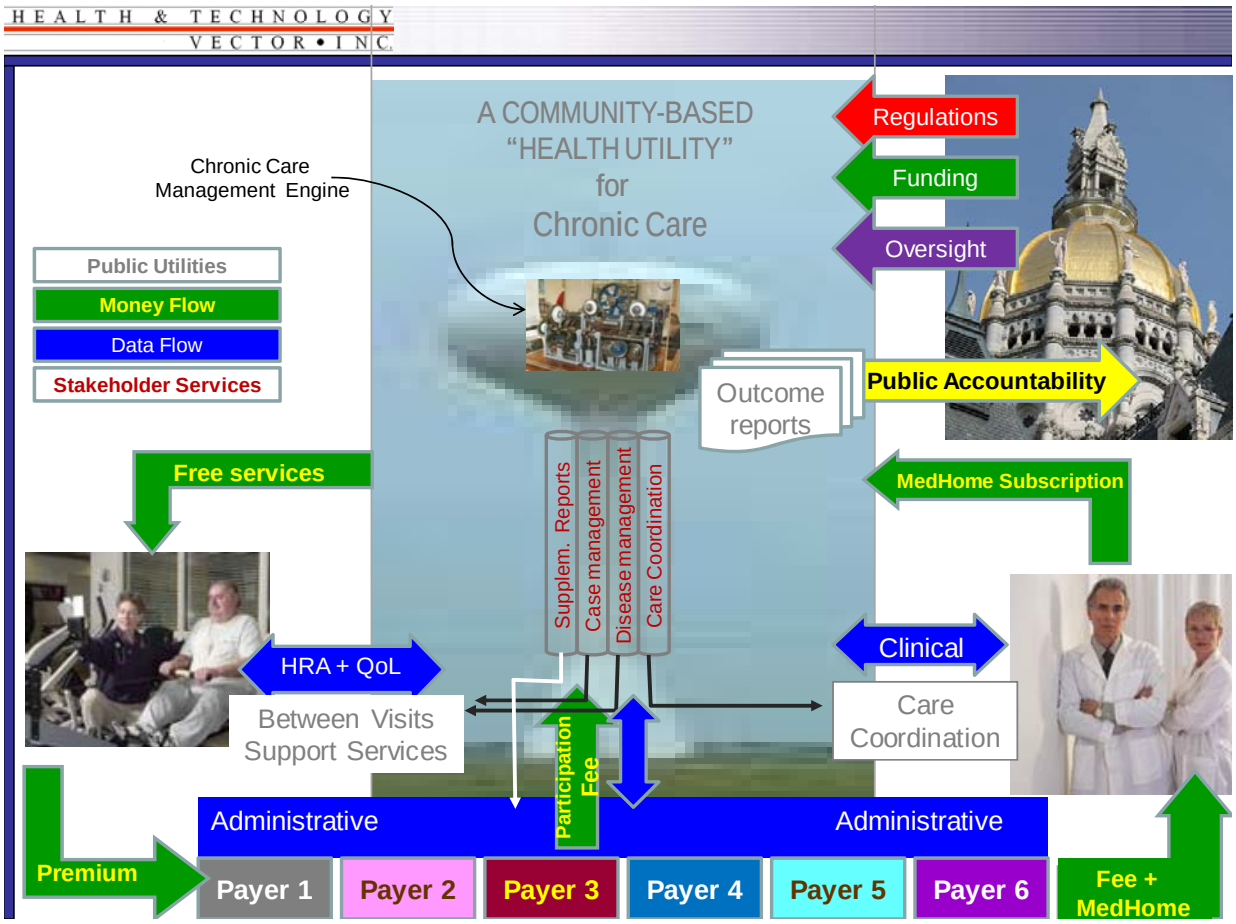
4. Increased efficiency in use of pharmaceuticals and diagnostic procedures through patient education and inter-provider care coordination.

5. Improved health outcomes and lower disability for people with common chronic conditions such as diabetes, heart failure, asthma and chronic obstructive pulmonary disease.

6. Development of a state-wide database and analytical infrastructure to quantify the value of public and private health care purchases (value-based purchasing) and to rationalize health policy decisions (ie.: answer the question "what are the state of CT top health care priorities?") .

7. To provide desperately needed support for primary care physicians, to enhance the professional satisfaction and to increase practice revenues from immediate eligibility for Medical Home and pay-for-performance payments.

Concept Schema



Appendix 5 – Health Information Technology & Exchange Recommendation

HealthFirst Connecticut Authority
Health Information Technology and Exchange Recommendations

December 11, 2008

The adoption of information technology (IT) has been necessary to enhance service, increase quality, and reduce cost in every information-intensive industry in the U.S. that has demonstrated these outcomes. The health care industry is one of the most information intensive of all, yet four out of five Connecticut physicians have not adopted IT to help them deliver patient care. As a result, patient information is generally not collected electronically and physicians are not able to take advantage of automated alerts, reminders, and diagnosis/treatment support tools to help them increase efficiency and quality. When patients move from physician office to specialist to hospital to home or long term care settings, their information must be faxed, called in, carried in paper folders, or recreated at every step. Incomplete and incorrect clinical data lead to unnecessary tests, unnecessary administrative cost, missed diagnoses, and medical errors. The result is higher cost than necessary, patient and provider dissatisfaction, compromised safety, and less than optimal care quality.

We recommend a two-pronged program to implement necessary information technology in Connecticut:

1. Accelerate the adoption of Health Information Technology (HIT) by individual physicians and other entities that currently do not have electronic health records systems. Electronic Health Records (EHR) systems include functionality to:

- collect patient demographics, history and problems
- enter diagnoses
- order medications, laboratory tests, medical procedures, and referrals to other providers
- communicate orders electronically via data interchange standards (this includes ePrescribing, where medication orders are entered electronically, the script is forwarded to the selected pharmacy, and the medication fill transaction and refill requests are sent back to the ordering clinician's EHR)
- receive notification that medications and other tests or procedures were performed, and automatically store results in electronic databases
- provide alerts and suggested clinical actions based on adopted guidelines of care.

The HIT program component must include support resources to help clinicians understand the characteristics and value of HIT, and to help them define their individual requirements, select, finance, procure and implement the technology. Financial incentives must be developed and implemented to accelerate adoption. Most Connecticut physicians are compensated by fee for service agreements, and these agreements should be amended to recognize the investment required for HIT. If they adopt HIT, physicians and other providers should be paid a premium by the purchasers and payers that benefit from cost containment and quality improvement. State of

Connecticut agencies that procure health services from the private sector should participate in these incentive programs, and look for creative ways to share savings with providers.

2. Implement Health Information Exchange (HIE) to enable individual HIT systems to interoperate statewide to access patient information in other health care organizations, wherever they might be. The HIE should be a shared utility, offering resources and technology services to any private or public entity that wishes to connect to the HIE and agrees to comply with adopted data sharing agreements, privacy policies, and technology standards. The HIE's technology services would include person and provider identification systems to link the different numbering schemes at different organizations, a record locator service to know where a patient's electronic records are stored, and privacy services to enable patients and providers to control access to their private information, in compliance with state and federal laws.

eHealthConnecticut, Inc., the organization incorporated in January 2006 to implement and sustain statewide HIE, should be engaged to pilot and develop HIE capabilities in Connecticut. eHealthConnecticut collaborators have been working for more than three years to develop HIE in the state, and have built trust and support among key health care stakeholders in the community. eHealthConnecticut is governed by a Board of Directors representing these stakeholders. It is a non-profit organization with a mission to enhance health care quality, safety and efficiency for all Connecticut residents. It operates in a transparent fashion, earning purchaser, payer, provider and consumer trust as a health information steward for all participants. eHealthConnecticut is working with state government leaders to develop a public-private partnership that is focused on the public good. The organization is developing a sustainable business model, where membership and usage fees collected will be commensurate with benefits produced.

Appendix 6 – Health Data Resource

The HealthFirst Connecticut Authority
Health Data Resource

Draft December 9, 2008

In order to implement health care reforms in Connecticut that are meaningful, it will be important to objectively measure actual results against initial expectations. It will also be important to understand, in detail, the varying levels of healthcare access and quality within our state, so that we can accurately target areas of improvement. To achieve these capabilities we must begin by creating a comprehensive health care data resource. This resource will include a technology warehouse for Connecticut health care data, advanced analytic resources and the security protocols necessary to safeguard information privacy and protect patient rights. There are a number of key elements that should be considered in the development of this resource:

Stewardship and Oversight

Given the importance of the health data resource, and independent board with relevant expertise should be established. (*This may include experts in areas of health information technology, health care research, privacy protection, consumer rights and medicine.*)

The board shall coordinate the establishment of the health care resource, including the selection of technology and analytic resources. It shall also be responsible for creating an environment that encourages the dissemination of health care data to a wide range of legitimate users (t*his could include business coalitions, consumer advocacy groups, academic institutions, employer groups, private healthcare analytic enterprises, and the general public*.)

Leverage the rapid advances in healthcare analytic technologies

Over the past few years there have been significant advances in the area of health care technology. These advances have increased the capacity to rapidly analyze huge databases while dramatically lowering the associated cost of computer hardware. (*Today, for example, there are analytic platforms that allow large health insurers with several million members to execute data queries down to the individual claim level within a matter of seconds, this would have been inconceivable five years ago.*) These systems are also designed to be efficiently modified and scaled upwards as new data sources (*such as electronic medical record data*) become readily available.

Analytic Resources

While it is easy to focus upon the value of new technology, the real value lies in the analytic capabilities and insight necessary to turn data into valuable information. In today's market, the development of these skill sets has lagged behind the pace of technology. Connecticut is fortunate to have public and private sector resources that could play a pivotal role in cultivating this resource.

(*Within State government, there currently exist analytic job functions at OCHA, DDS, and DPH, these resources could be combined, retrained or redirected. Both Yale and UCONN have valuable expertise in* this area. *In addition, local private sector resources have significant analytic capabilities that should also be considered.*)

A Statewide Data Warehouse

The cornerstone of the data resource initiative will be the establishment of a statewide data warehouse. Traditional sources of data will initially be collected (T*hese sources would be comprised of insurance claim, membership and provider data*). It is anticipated that these sources would be expanded over time as new and emerging sources of information become available. (These data sources would create a robust data base that would help 1) develop measures of improved quality of care, 2) improve the monitoring of health care access, 3) help maximize value and promote cost effective health care and 4) development of a system based upon transparency so that all parties are equally informed.)

Scope of Participation

The benefits of a health information repository will accrue to all parties; consequently, all significant payers, public and private, (*including self insured and fully insured employers*) would be obligated to periodically submit relevant claim, membership and provider data. Any private payer, including third party administrators, with Connecticut membership of greater than 5,000 members would be considered a significant payer and therefore required to submit information. It is expected that current electronic data transfer protocols and formats currently utilized by the major payers would be utilized, to the extent possible) in order to minimize any additional burden created as a result of this requirement.

Protection of patient confidentiality and integrity of use

It will be important to establish a data infrastructure that balances the need to disseminate data to legitimate users, while protecting confidentiality. The Research Data Assistance Center (ResDAC) is an entity charged by CMS with the responsibility to manage the release of health care data for both, the Medicaid programs. A similar function, modeled after the ResDac could be adopted in Connecticut.

As we institute changes to our health care system it will be imperative that these changes benefit the maximum number of people at the lowest possible cost. It will also be important to insure that the care rendered is of uniformly high quality, and that this quality improves over time. To do this, it will be necessary for all stake holders to embrace the need for a comprehensive statewide data resource.

Appendix 7 – Health Care Workforce Initiative

Health Care Workforce Initiative

HealthFirst Connecticut Authority
Policy Brief
DRAFT FOR DISCUSSION ONLY

VISION

Connecticut will have a qualified healthcare workforce that is sufficient to meet the changing demands of the health care environment and the needs of its people.

BACKGROUND

Connecticut's health care reform efforts must be coupled with a coherent aggressive strategy to increase healthcare workforce numbers. Connecticut as well as the rest of the nation is facing ever increasing healthcare workforce shortages. In order to have access to health care services, Connecticut must have a qualified health care workforce to deliver that care. In 2011, the first of the Baby Boomer will turn 65. Their sheer numbers in addition to their increased use of health care services will strain an already dysfunctional health care system.

According to the Connecticut Department of Labor, the majority of Connecticut's health care demands are in the nursing profession; however, the 2002-2012 occupational forecast data show a strong, long-term demand for professionals in the dental, pharmaceutical, and therapy professions. The following occupations are forecasted to provide the most total annual openings, due to industry growth and the need to replace retirement-age health care workers.

Connecticut Health Care Occupations with the Most Total Annual Openings

Occupational Title	Employment		Total Annual Openings	Change (+/-)	Wages
	2002*	2012*			
Registered Nurses	31,400	36,600	1,181	5,200	$57,283
Licensed Practical and Licensed Vocational Nurses	7,400	7,900	208	500	$45,594
Pharmacists	2,700	3,200	105	500	$80,392
Radiologic Technologists and Technicians	2,900	3,400	100	500	$47,278
Dental Hygienists	3,100	3,700	88	600	$58,760
Physical Therapists	3,100	3,600	84	500	$66,269
Pharmacy Technicians	2,500	3,000	84	500	$26,416
Emergency Medical Technicians and Paramedics	2,800	3,200	68	400	$30,826
Dentists	3,000	3,200	65	200	$131,810

*Note: *Employment figures have been rounded to the nearest hundred.***Source: Hooker, Brandon T., et al., Connecticut's Health Care Occupations: A Window of Economic Opportunity, Connecticut Department of Labor, Hartford, CT, March 2005, www.ct.gov/dol**

The most recent survey conducted by the Connecticut Hospital Association (CHA) shows that as of December 31, 2006, its member hospitals are experiencing vacancy rates for several critical professions ranging from 6% to 11%[37].

Key Healthcare Profession Vacancy Rates in Connecticut
and Translation to
Full Time Equivalent Employees (FTEs)
As of December 31, 2006

Position	Vacancy rate	Full Time Equivalent Employees
Staff RN	6.6%,	720 FTEs
Emergency Department RNs	10.9%	115 FTEs
Critical Care RNs	7.8%	140 FTEs
Medical-Surgical RNs	7.6%	245 FTEs
Psychiatric RNs	10.4%	50 FTEs
Nurse Managers	7.0%	35 FTEs
Pharmacists	7.3%	35 FTEs
Respiratory Therapists	8.4%,	50 FTEs
Physical Therapists	9.5%	35 FTEs
Physician Assistants	6.2%	30 FTEs
Surgical Technologist	5.9%	30 FTEs
Unlicensed Assistive Personnel	6.3%	230 FTEs

Source: Connecticut Hospital Association, Averting Crisis: Ensuring Healthcare for Future Generations in Connecticut, http://www.chime.org/advocacy/documents/Averting_Crisis-HCWorkforceReport.pdf

A report by the U.S. Department of Health and Human Services puts the shortage of nurses at 21,791 in the year 2020 in Connecticut. Nationally, the shortage of nurses is estimated at 808,416 in 2020.[38] By 2020, Connecticut is projected to have the 2nd worst shortage of registered nurses in the nation.[39] Alaska will have the worst shortage in the nation.

The Association of American Medical Colleges predicts shortages of physicians in the future if efforts aren't implemented to increase the number medical students in the pipeline.[40] Nearly a quarter of the current active physician workforce in Connecticut is aged 60 year of age or older. Connecticut must improve its retention of medical students, residents and fellows if there is to be an adequate supply of physicians in the future.

[37] Connecticut Hospital Association, Averting Crisis: Ensuring Healthcare for Future Generations in Connecticut, http://www.chime.org/advocacy/documents/Averting_Crisis-HCWorkforceReport.pdf.

[38] U.S. Department of Health and Human Services, Health Resources and Services Administration, Projected Supply, Demand, and Shortages of Registered Nurses 2000-2020, July 2002.

[39] U.S. Department of Health and Human Services, Health Resources and Services Administration, Projected Supply, Demand, and Shortages of Registered Nurses-2000-2020, July 2002, http://www.ahcancal.org/research_data/staffing/Documents/Registered_Nurse_Supply_Demand.pdf

[40] Association of American Medical Colleges, 2007 State Physician Workforce Data Book, http://www.aamc.org/workforce/statedatabookjan2008.pdf.

Supply Versus Demand Projections for FTE Registered Nurses Connecticut and US 2000-2020

Year		Supply	Demand	Excess or Shortage	Percentage of shortage
2000	CT	26,407	30,137	-3,730	-12%
	US	1,889,243	1,999,950	-110,707	-6%
2005	CT	24,175	31,919	-7,744	-24%
	US	2,012,444	2,161,831	-149,387	-7%
2010	CT	22,422	34,158	-11,736	-34%
	US	2,069,369	2,344,584	-275,215	-12%
2015	CT	19,841	36,786	-16,945	-46%
	US	2,055,491	2,562,544	-507,063	-20%
2020	CT	17,870	39,661	-21,791	-55%
	US	2,001,998	2,810,414	-808,416	-29%

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Projected Supply, Demand, and Shortages of Registered Nurses-2000-2020, July 2002.

A recent Health Care Industry Cluster study identified growing workforce shortages as the most important issue affecting the prospects of southwest Connecticut's health care industry.[41] Regional and statewide shortages across several health care occupations threaten the capacity of health care providers to offer the increasing level of service needed by the region's aging population. Registered nursing has rightfully received the most attention across the state; however, shortages are also growing in numerous other health care occupations:

- radiologic technologists,
- CT and MRI technicians,
- pharmacists and pharmacy technicians,
- physical therapists and physical therapist assistants,
- medical assistants and occupational therapists as occupations with shortages of qualified candidates.

According to the Governor's Hospital System Strategic Task Force the shortage of health care professionals (e.g., physicians, nurses, and allied health) limits access to primary care, medical specialties and exacerbates emergency department "on-call" coverage pressures. [42] The Task Force reported that Connecticut's physicians, along with representatives from the Connecticut State Medical Society, highlighted the severity of physician shortages in Connecticut, particularly in subspecialty

[41] Holt, Wexler, Farnam, LLP, Health Care Industry Cluster Study, December 2006, http://www.businessfairfield.com/webpdf/OneCoastHealthStudy.pdf.

[42] Governor's Hospital System Strategic Task Force, Hospital System Strategic Task Force Findings and Recommendations, January 2008, http://www.ct.gov/ohca/lib/ohca/taskforce/hospitaltaskforce/hospital_task_force_master_version_1-17-08.pdf.

areas.[43] According to the Task Force, the shortage is linked to several issues. Since Connecticut has one of the highest costs of living in the nation, it is difficult for the state to retain or attract recent medical student graduates, as they cannot afford to establish and maintain a practice, raise a family and pay back significant student loans.[44] It is believed that physicians and recent medical school graduates are choosing to practice in other states with a lower cost of living, limitations on medical malpractice claims and fewer on-call requirements.[45]

Physician Workforce-2007

	United States	Connecticut	Connecticut Rank
Active physicians per 100,000 population	249.7	318.4	4
Active primary care physicians per 100,000 population	88.1	101.8	9
Physicians in residencies and fellowships per 100,000 population	35.6	57.3	5
Number of current medical students educated per 100,000 population	29.2	24.5	26
Percent Active physicians in-state who completed a residency or fellowship in state	44.8%	39.6%	14
Percent Active physicians in-state that completed undergraduate medical education in state	28.6%	9.9%	40
Percent Active Physicians age 60 years of age or older	23.3%	24.3%	10

Source: Association of American Medical Colleges, 2007 State Physician Workforce Data Book, http://www.aamc.org/workforce/statedatabookjan2008.pdf

Several factors contribute to healthcare workforce shortages:

- **Faculty shortages –** Many qualified candidates have been turned away from Connecticut nursing and allied health programs in the last three years due to lack of capacity to train them. Two major issues explain faculty shortages: 1) Teaching faculty are required to have a Master's degree, which few Registered Nurses and allied health care workers have; and 2) Wages for teaching faculty are not competitive with the wages Master's level professionals can earn providing direct care, particularly in high cost areas like southwestern Connecticut.

The Connecticut Allied Health Workforce Policy Board (AHWPB) commissioned the *Nursing and Allied Health Faculty Staffing Plan Study Report,* which was completed by Belón Research & Practice in January 2007. This Report confirmed that "qualified faculty that possess the requisite degrees are in short supply across the allied health spectrum" and found that "the number of at-risk programs is significant."

[43] Ibid.
[44] Ibid.
[45] Ibid.

- **Lack of clinical placements –** A lack of sites available for students to complete their clinical requirements and underutilization of existing clinical sites also limits the training capacity of the State's higher education infrastructure.

The Connecticut Hospital Association (CHA) completed its *Clinical Placement Capacity Assessment Project Report* in July 2007. This report concluded that "the 'clinical placement problem' in Connecticut stems from the exhaustion of opportunities in some clinical specialties and misdistribution to a small extent." The report also states that "coordination and logistical issues exacerbate an already strained process."

The CHA report demonstrates an acute lack of clinical placement capacity in southwestern Connecticut, as registered nursing schools need 4,935 clinical placements annually while hospitals can offer only 2,471 clinical placement opportunities – a 50% shortfall. A current method of addressing this shortage is having students travel to placements outside the region.

- **Classroom and Laboratory Space –** If nursing and allied health programs were able to attract additional faculty for expansion, they would soon run into a serious space constraint in existing facilities.
- **Lengthy academic program approval process –** The process for a college to obtain state approval for a new program area does not allow colleges to quickly respond to the changing hiring needs of health industry employers. The process for getting a new program off the ground typically takes two to three years.
- **Inadequate student preparation –** Many students emerging from the region's K-12 public school systems lack the science, math, and English skills needed to succeed in college and university nursing and allied health programs. Nationally, 42 percent of community college freshman and 20 percent of freshman in four-year institutions enroll in at least one remedial course representing almost one third of all freshman.[46] The leading predictor that a student will drop out of college is the need for remedial reading.[47] Students who enroll in a remedial reading course are 41 percent more likely to drop out of college.[48]

While published data was not available on students enrolled in remedial reading, about 19 percent of students enrolled in Connecticut's Community College system are enrolled in remedial math. At Western Connecticut State University, approximately 52.4-57.4 percent of Freshman (Fall 2002, 2003, respectively) required at least one remedial course at the time of entry.[49]

Low student academic readiness often results in low retention rates and a smaller pool of candidates to complete the credentialing process and enter the health care workforce. This also means that a significant proportion of scarce public educational resources are expended on students who do not complete their course of study while others who might complete are denied access due to lack of program capacity, suggesting a need for better counseling and screening for entry.

- **The achievement gap –** The persistence of a dramatic achievement gap in our K-12 education system restricts the state's ability to produce a qualified, diverse health care workforce. Significant gaps exist between boys and girls in reading, and between White students and their

[46] Alliance for Education, Paying Double: Inadequate High Schools and Community College Remediation, August 2006, www.all4ed.org.
[47] Ibid.
[48] Ibid.
[49] Western Connecticut State University, Building a Bridge to Improve Student Success: A Collaborative Project between Western Connecticut State University and Area High Schools, undated, www.wcsu.edu.

Black and Hispanic classmates and between poor and non-poor students in reading and mathematics.

With regard to the 2007 8th grade reading scores Connecticut has:

- The largest gap in the nation with regards to poor/non-poor students.
- The second largest Hispanic/White gap in the nation; and
- The third largest Black/White gap in the nation (tied with Arkansas).[50]

With regard to 2007 8th grade mathematics scores Connecticut has:

- The largest gap in the nation with regards to poor/non-poor student and Hispanic/White students.
- The fifth largest gap in the nation with regards to Black/White students.[51]

NAEP Scores
Percent of Eighth Graders Reading at or Above National Goal (At or above proficient)
2007

Racial/Ethnic Group	Mathematics		Reading	
	CT	US	CT	US
Black	7	11	12	12
Hispanic	10	15	14	14
Asian/Pacific Islander	61	49	45	40
White	44	41	46	38
Total	**34**	**31**	**38**	**29**
Gender				
Male	35	33	31	24
Female	34	29	43	34
Eligibility for free/reduced-price school lunch				
Eligible	10	15	14	15
Not eligible	44	42	45	39

Source: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, National Assessment of Educational Progress (NAEP), 2007 Report Card, www.nationsreportcard.gov

- **"Brain Drain" –** Exacerbating training capacity and student preparation problems is the difficulty health care employers face in hiring health care program graduates. A lack of affordable housing and a high cost of living make it difficult to attract and retain health care workers. From 2000 to 2006, Connecticut's population grew by only 2.9 percent earning Connecticut a rank of 37 nationally in terms of percent change in population.[52] However, during this same time period Connecticut's population 25 to 34 years of age decreased 9.6 percent or by 43,459

[50] The Education Trust, The Ed Trust Statement on the 2007 Math and Reading Scores from the Nation's Report Card, http://www2.edtrust.org/EdTrust/Press+Room/NAEP2007.htm.
[51] Ibid.
[52] Gittell, Ross and Timothy Lord, Demographic Alert Update- Mid-Decade Population Trends in New England, continued Concern about the Decline of the Young Population. Fall 2007, Carsey Institute, University of New Hampshire, www.carseyinstitute.unh.edu.

persons earning Connecticut a rank of 49th nationally. Only one state, Massachusetts lost a higher percentage of the young adult population during this time frame. Additionally, Connecticut ranks in the bottom states nationally in terms of the percent of the population total aged 25 to 39 years earning a rank of #48. Nationally, 13.5 percent of the population is aged 25 to 39 years of aged compared to 11.6 percent of the population in Connecticut.

- **An aging workforce –** Underscoring the importance of keeping qualified, young workers in Connecticut is the fact that older health care workers are beginning to retire in large numbers. Between 2000 and 2030, the population 65 years of age and over is expected to increase 69 percent.

Connecticut Population 2000-2030

AGE	2000		2030		Change 2000-2030	
	Number	% of Population	Number	% of Population	Number	Percent
65+	470,183	13.8	794,405	21.5	324,222	+69.0
45-64	789,420	23.2	852,893	23.1	63,473	+8.0
25-44	1,032,689	30.3	935,506	25.4	-97,183	-9.4
18-24	271,585	8.0	282,390	7.7	10,805	4.0
Under 18	841,688	24.7	823,436	22.3	-18,252	-2.2

Source: U.S Bureau of Census, http://www.censusscope.org/

- **Tuition is an important factor affecting access to post secondary education.** The cost of post secondary education in Connecticut is among the highest in the nation. In 2006, Connecticut earned an "F" in terms of affordability of college education.[53] The University of Connecticut ranks among the top ten most expensive state universities in terms of tuition and fees on a national (9th) and regional (6th) basis while, the Connecticut State University system ranked among the top 20 most expensive state universities in terms of tuition and fees a national (13th) and regional (6th) basis. Similar results were reported for the Connecticut Community Technical College (CTC) system; the CTC system ranked among the 8th most expensive regionally and 22nd most expensive nationally in terms of tuition and fees.

Families rely on student loans to cover the rising cost of tuition, books, and living expenses. Connecticut ranks 4th nationally for high average student debt at $23,469. The District of Columbia, New Hampshire, and Vermont ranked 1st, 2nd, and 3rd respectively.[54]

- **Lack of infrastructure to train immigrants –** Connecticut has a growing immigrant population. Immigrants of all skill levels can help to fill gaps in the regional health care workforce, but many require customized training and case management-style support. Connecticut has a growing

[53] The National Center for Public Policy and Higher Education, Measuring Up-2006 The State Report Card on Higher Education, www.highereducation.org.
[54] The Project on Student Debt, The Project on Student Debt-Student Debt and the Class of 2006, September 2007, http://projectonstudentdebt.org.

immigrant population. Individuals who are leaving the state are being replaced with immigrants from other countries.

Cumulative Estimates of the Components of Population Change for Counties of Connecticut April 1, 2000 to July 1, 2006							
Geographic Area	Total Population Change*	Natural Increase			Net Migration		
		Total	Births	Deaths	Total	Net International Migration	Net Internal Migration
Connecticut	**99,207**	**70,748**	**256,735**	**35,987**	**9,510**	**92,635**	**53,125**
Fairfield County	17,873	29,633	72,788	43,155	-8,925	43,811	-52,736
Hartford County	19,744	14,143	63,711	49,568	8,608	21,111	-12,503
Litchfield County	7,907	1,397	11,760	10,363	7,049	1,278	5,771
Middlesex County	8,703	2,618	10,959	8,341	6,540	1,736	4,804
New Haven County	21,236	13,080	61,852	48,772	10,996	19,566	-8,570
New London County	4,187	5,082	19,092	14,010	-123	1,957	-2,080
Tolland County	11,776	3,086	8,653	5,567	8,984	1,968	7,016
Windham County	7,781	1,709	7,920	6,211	6,381	1,208	5,173

*Total population change includes residual - see "State and County Terms & Definitions"

Note: The April 1, 2000 estimates base reflects changes to the Census 2000 population resulting from legal boundary updates as of January 1 of the estimates year, other geographic program changes, and Count Question Resolution actions. All geographic boundaries for the July 1, 2006 population estimates series are defined as of January 1, 2006. Dash (-) represents zero or rounds to zero.

Source: Population Division, U.S. Census Bureau, March 22, 2007

Table 4: Cumulative Estimates of the Components of Population Change for Counties of Connecticut: April 1, 2000 to July 1, 2006 (CO-EST2006-04-09)

According to the Census Bureau, Connecticut ranks 11th nationally in terms of the percent of foreign-born population; 12.9 percent of Connecticut's population foreign born.[55] Nationally, 12.5 percent of the population is foreign born.

A study by the Connecticut Legislative Program Review and Investigation Committee found the need for adult basic services and English as a Second Language (ESL) services far exceeds the current program capacity.[56] Based upon the latest census data 12.1 percent of Connecticut's population, or 324,349 persons, 18 years age and over do not have a high school diploma. Approximately 8 percent of Connecticut's population or 260,916 people over 5 years of age and over speak English "less than well". Connecticut ranks 14th nationally in terms of population 5 years and over that speak English "less than

[55] United States Bureau of Census, 2006 American Community Survey, Percent of Population Who Are Foreign Born: 2006, http://factfinder.census.gov/servlet/GRTTable?_bm=y&-geo_id=01000US&-_box_head_nbr=R0501&-ds_name=ACS_2006_EST_G00_&-_lang=en&-redoLog=false&-format=US-30&-mt_name=ACS_2006_EST_G00_R1603_US30&-CONTEXT=grt .

[56] Program Review and Investigations Committee, Coordination of Adult Literacy Programs-Findings and Recommendations, December 14, 2006.

very well". Clearly the numbers tell us that Connecticut will need to develop a strategy to integrate new arrivals into the workforce force.

- **Underrepresented demographic groups –** More men, blacks, and Hispanics will need to be drawn into the health care workforce if the State hopes to avoid long-term shortages, particularly in nursing.
- **Lack of data on health care workforce.** One of the ten essential public health functions is to assure a competent public health and personal health care workforce.[57] While the Department Of Public Health is responsible for practitioner licensing, the Department does not know how many doctors are actually involved in patient care, the actual number of doctors practicing under each specialty in patient care, or the trends in physician employment in Connecticut.[58] Additionally, many nurses hold more that one license making it difficult to determine the actual numbers of nurses practicing in Connecticut.

Study after study has confirmed the need for better data on Connecticut's health care workforce:

- The 1994 Connecticut Program Review and Investigations Committee *Health Cost Containment Study,*[59]
- Connecticut Department of Public Health, *Health Workforce Shortages A Review of Available Data and Measures for Selected Professions*[60], May 2001;
- Connecticut Department of Public Health, *A Study Concerning the Shortage of Nurses and Quality of Patient Care in Connecticut: Phase I and II*, 2000, 2001[61];
- Connecticut Program Review and Investigations, *Medical Malpractice Insurance Rates*, December 2003, Hartford, CT[62].

The new on-line licensing system renewal system for physicians, surgeons, dentists, and nursing, funded by the Legislature ($1,645,000 in FY08) must be designed to provide data that can be used for education, recruitment, marketing and forecasting Connecticut's healthcare workforce needs.

RECOMMENDATIONS

Simply put, Connecticut does not have a cohesive state action plan that looks at recruitment, retention, mentoring, marketing and education of health care professionals. There are at least 20 different entities that have a role in preparing Connecticut's health care workforce including the following: State Department of Education, State Department of Higher Education, State Department of Public Health, Connecticut Medical Examining Board, Connecticut Board of Nursing Examiners, Connecticut Department of Labor, Connecticut Community Technical Colleges, Connecticut State University System, University of Connecticut, private colleges and universities, Connecticut's hospitals, unions representing

[57] Public Health Functions Steering Committee, Members, (July 1995, http://www.health.gov/phfunctions/public.htm.

[58] Connecticut Program Review and Investigations Committee, Medical Malpractice Insurance Rates, December 2003, Hartford CT.

[59] Connecticut Program Review and Investigations Committee, Health Cost Containment Study, 1993, http://www.cga.ct.gov/pri/Publications.htm.

[60] Connecticut Department of Public Health, *Health Workforce Shortages A Review of Available Data and Measures for Selected Professions,* May 2001.

[61] Connecticut Department of Public Health, *A Study Concerning the Shortage of Nurses and Quality of Patient Care in Connecticut: Phase I and II*, 2000, 2001.

[62] Connecticut Program Review and Investigations, *Medical Malpractice Insurance Rates*, December 2003, Hartford, CT, http://www.cga.ct.gov/2003/pridata/Studies/Medical_Mal_Final_Report.htm.

faculty members and health care workers, Connecticut Medical Society, Connecticut League for Nursing, Connecticut Allied Health Policy Board, Connecticut Career Ladder Advisory Committee, Connecticut Advisory Council on Student Transfer and Articulation, Connecticut Employment and Training Commission, Office of Workforce Competitiveness, Regional Workforce Development Boards, Connecticut Area Health Education Centers, and the Connecticut Adult Literacy Board.

Each entity has defined the issue from its own perspective, resulting in a wide range of potential policy recommendations. No comprehensive strategic framework has yet to be developed which incorporates all of the concerns of all of the groups.

Develop a Strategic Healthcare Workforce Plan and Produce An Annual Healthcare Workforce Scorecard

A separate *Health Care Workforce Planning Branch* should be created and funded within the Connecticut Department of Public Health to coordinate all programs designed to increase the training, recruitment and retention of health care workers in conjunction with other work force initiatives. This Branch would be responsible for developing a Strategic Healthcare Workforce Plan with a new expanded Allied Health Policy Board.

The Legislature should review the composition of and expand membership of the Allied Health Policy Board to ensure that the workforce needs of the entire health care field are represented. Membership should be expanded to include physicians and representatives of organized labor.

The new board, *Connecticut Health Care Workforce Strategy Board*, would be responsible for:

(1) Assisting the Department of Public Health's new Health Care Workforce Branch in developing a Five Year Health Care Workforce Strategic Plan for Connecticut and producing an "Annual Connecticut Health Care Workforce Scorecard" that identifies specific numerical production targets for each health care occupation and reports on the number of individuals that graduate from the Connecticut's higher education institutions. Specific workforce goals will express the importance and urgency of action as well as provide a clear standard against which progress can be measured.

(2) Working with the Connecticut Department of Higher Education, The Connecticut Office of Information Technology, and the Advisory Council on Student Transfer and Articulation to increase transparency of the higher education system by formalizing articulation agreements and developing an on-line student transfer information system.[63] Connecticut lags behind other states in providing accessible information to students.

[63] Connecticut post secondary schools have a hodge- podge of articulation agreements that make it difficult for students to see how credits earned at any Connecticut college or university can be applied when transferred to another. The State Department of Higher Education should develop an on-line student transfer information system to build upon recent agreements between the Community College System, University of Connecticut and the Connecticut State College University system. An example of a best practice is California's ASSIST. ASSIST is the official repository of articulation for California's public colleges and universities and provides the most accurate and up-to-date information about student transfer in California (http://www.assist.org/web-assist/welcome.html). Another best practice is New Jersey Transfer found at http://www.njtransfer.org/. NJ TRANSFER was developed as

(3) Creating a study committee with representation from the Connecticut Department of Higher Education, the Connecticut Office of Information Technology, representatives from the Connecticut's Community Colleges, public and independent four year colleges and universities, health care providers and simulation users to develop a plan for deployment of simulation capacity in all regions of the state for multi-sector, multidisciplinary and interdisciplinary use for health care workforce development, including pre- and post-service, career ladder and re-entry/refresher programs.

(4) Work with the Career Ladder Advisory Committee to identify career paths and ladders within the healthcare sector including how coursework in one career path can be applied to satisfy coursework require for another occupation.[64]

(5) Providing support to the Department of Public Health to expand the capacity of the on-line licensure system approved during the 2007 legislative session to include all healthcare professionals by 2010 and establish a comprehensive database of licensed healthcare professionals that includes, but is not limited to, the following information about the licensee: type of license held, whether the licensee is working, position held, how long at current position, name of employer, employer's type of industry, highest level of education, number of hours providing direct patient care per week.

Create Health care Workforce Partnerships in each of the five workforce development areas to coordinate the region's health care workforce development efforts and provide assistance to the Connecticut Health Care Workforce Strategy Board.[65] Modeled on partnership efforts in several regions of the country, the partnership would:

a) Coordinate efforts among key stakeholders (employers, the workforce development system, AHEC, and education institutions including feeder high schools) to identify and prioritize employer needs and specific opportunities to meet them efficiently through joint actions and advocacy;

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a joint initiative of the New Jersey Commission on Higher Education and the New Jersey Presidents' Council. Its many features assist students in learning:

- Which courses to select at a community college
- Which New Jersey four-year colleges offer equivalent courses
- How the courses will satisfy four-year degree requirements
- Where students can transfer their community college courses in New Jersey
- How to contact a New Jersey college or university if additional information about admissions, transferring courses, or transfer recruitment events is needed.
- Which professional fields are in high demand in the State, as well as other job opportunities?

[64] Career Ladders and Paths. The website should also identify how coursework can be applied to various career paths and ladders. For example, how could coursework taken to prepare for a career to become a paramedic or certified nursing assistant can be applied to satisfy coursework required for a nursing degree.

[65] Connecticut created Workforce Development Boards in 1992, basing them on existing business-led Private Industry Councils. The membership of the Boards also includes representatives of community-based organizations, state and local organized labor, state and municipal government, human service agencies, economic development agencies, community-technical colleges and other educational institutions, including secondary and post-secondary institutions and regional vocational technical schools. Boards administer employment and training activities at the local level in eight regions of the state, working in partnership with local elected officials. Under the Workforce Investment Act, Boards are given increased authority for oversight, strategic planning, and policy-making at the local level (in continuing close collaboration with local elected officials). The five boards are: Capital Workforce Partners; Eastern CT Workforce Investment Board; Northwest Regional Workforce Investment Board, Inc, Workforce Alliance, and The Workplace, Inc.

b) Spearhead projects intended to produce tangible outcomes;

c) Develop capacity, including pursuing funding opportunities to fill gaps in services;

d) Coordinate attraction, training, placement, and retention of quality health workers through marketing and awareness strategies and

e) Develop, gather, and share regional health workforce data.

Make Better Use of Technology

Implement a 3 year regional pilot of a web-based centralized clinical placement system in southwestern Connecticut – Web-based centralized clinical placement (CCP) systems use online scheduling systems to match students from participating schools with clinical placement opportunities at participating clinical sites. The goals of CCP systems are to:

a) Increase the overall number of available clinical sites;

b) Decrease the faculty and staff clinical hours needed to arrange clinical site time;

c) Decrease the cost to schools and clinical facilities of placing students;

d) Provide an early alert system when clinical sites become available; and

e) Provide a forum to increase communication about issues facing education and workforce development.

CCP systems in other states have increased clinical capacity by as much as 38% while reducing clinical placement turnaround time from 16 days to two days and reducing the staff time needed to coordinate clinical placements. A regional pilot would require an annual investment of approximately $68,000 for the "StudentMax" CCP software system currently used by 11 states, a (half-time) Program Coordinator, and meeting costs.

Implementation will require three critical actions: (1) convening a critical mass of education programs and clinical facilities willing to join in the project and work out the by-laws governing the operation of the system; (2) securing seed funding for start-up and at least three years of pilot implementation, and (3) identifying a neutral and efficient operating entity to broker the process.

Expand the availability of nursing and/or allied health distance learning courses – Distance learning would expand the state's capacity to produce nursing and allied health graduates without significant investments in physical infrastructure. Several challenges, including faculty and clinical shortages and the time and funds needed to create online programs, must be addressed before distance learning can substantially increase the capacity of the higher education system. Funding should be provided to Charter Oak College to partner with St. Vincent's College or another institution to develop an on-line nursing program.

Expand use of simulation capacity based upon the results of the Connecticut Health Care Workforce Strategy Board Plan for Simulation Deployment in Connecticut.

Increase awareness of Health Careers in Connecticut and Help Students Develop the Skills Needed to Succeed in the Workforce

Increase awareness of health careers among high school students. Establish a six (6) week paid summer healthcare career internship program for 100 high school students interested in pursuing a career in health care in each of the five (5) workforce development regions. Students will learn soft skills/job readiness training during the first week of their internships. Students will learn to take vital signs, first aide/CPR/AED, intake, and general health assessment. Students will be exposed to a multitude of health care professions by shadowing health care professionals in a variety of departments during the summer. Workshops will be held to help students understand the science, math and other requirements they will need in order to prepare them for the training they will need for health careers. Many of the AHECs have established Medical Camps for high school students.

Internships for college students enrolled in a health career program of study. Assist health care employers with offering paid Internships to college students enrolled in a health careers program of study. Internships expose students to academic, cultural, and social opportunities in Connecticut and strengthen ties to the area.

Establish a pilot nursing residency program to provide mentoring to first-year hospital-based nurses in order to increase nurse retention rates and to smooth their transition from school to clinical practice

Create Connecticut Health Careers Website- Information on health careers in Connecticut is not cohesively presented in one location. The Connecticut Department of Public Health in conjunction with The Connecticut Health Care Workforce Strategy should develop a Connecticut Health Careers Website that provides a comprehensive suite of services including:

- Description and educational requirements of various health occupations and career pathways (examples: Health Careers in Connecticut at http://www.healthcareersinct.com/; New York Health Careers at http://www.healthcareersinfo.net/index.php?id=1)
- Scholarships and financial aid (examples: Florida Bright Futures, http://www.floridastudentfinancialaid.org/ssfad/bf/; Georgia's Hope Scholarship program, http://www.gsfc.org/Main/publishing/pdf/2004/hope_maintain.pdf)
- On-line student-transfer information system would provide an electronic platform for academic planning, supplying articulation information to students and advisors. Such a system would greatly benefit health care students system and increase transparency of higher education (examples: California, www.assist.org; New Jersey, www.njtransfer.org).
- Centralized faculty resource center indicating faculty openings and information on how to become a faculty member (examples: Bay Area Nursing Resource Center http://www.iteachnursing.org/, Massachusetts Nursing Center, http://www.nursema.org/become_faculty.html).
- Centralized Clinical Placements (examples: Oregon Center for Nursing, http://www.ocnplacement.org/)
- Retention and recruitment best practices (examples: Florida Center for Nursing, http://www.flcenterfornursing.org/retention/index.cfm)
- Resources to Immigrants (examples: Boston's Welcome Back Center for foreign born nurses http://www.bhcc.mass.edu/inside/18

- Health Tutorial Resources for students such as University of Minnesota's Web Anatomy at http://msjensen.cehd.umn.edu/WEBANATOMY/, Health Tutorials at http://www.khake.com/page92.html)

Develop a central resource for immigrants with foreign health care experience to help them gain employment in the regional health care industry – Immigrants who hold health care experience in their home countries could help to fill gaps in the regional health care workforce, but many immigrants need "bridge" programs to help them connect to the training needed to gain employment in the health care industry or even become accredited in their profession. Boston has created a Boston's Welcome Back Center for persons who were nurses in other countries become registered nurses in Connecticut (http://www.bhcc.mass.edu/inside/18). This project will identify two potential populations:

- Immigrants, who completed post-secondary nurse education in their native country that is equivalent to the training required for nurses in the U.S. This population will receive coaching and assistance in applying for credential CGFNS and the Board of Nursing Registration, high-level ESOL, and NCLEX test preparation.
- Immigrants who have completed post-secondary training in their native country as nurses or other clinical care professions, but such training was not equivalent to the training required for nurses in the U.S. This population will receive college and career planning services, including financial panning assistance as well as college-prep ESOL.

Remove financial barriers to higher education

Connecticut should increase access to higher education by providing full tuition and living expenses to all students in Connecticut wanting to pursue post secondary education in identified health occupation shortage areas in exchange for a commitment to work in Connecticut following program completion.

Connecticut's higher education system is one of the most expensive in the nation and creates barriers to post secondary education or straps our workforce with huge college loans. Other states and nations have recognized the value of a highly educated workforce by offering tuition to students. The State of Florida and Georgia provide tuition to students who maintain a certain Grade Point Average (e.g. Florida's Bright Futures program funded by the lottery). Investment in human capital became a strategic objective as part of Ireland's national planning process in the mid 1990. The government of Ireland made a decision to invest publicly in a fully accessible and affordable post-secondary system; every student with the interest and the academic qualifications, regardless of financial capabilities, has access to basic post-secondary education through a tuition free policy.

Support Increased Salaries for Community College Nursing Faculty

Two factors explain nursing faculty shortages: 1) teaching faculty are required to have a Master's degree; 2) wages for teaching faculty are not competitive with the wages Master's level professionals can earn providing direct care. Additionally, community college faculty members in high-cost areas (like Southwest Connecticut) earn the same as comparable faculty in lower-cost areas due to statewide collective bargaining agreements.

We encourage the Community College System and its faculty unions in their current effort to increase salaries for nursing faculty by allowing more competitive salaries in shortage occupations and negotiating greater flexibility to adjust compensation based on differences in regional living costs.

Connecticut Towns Listed by Workforce Investment Area (WIA)

Effective July 2003

Eastern Workforce Investment Area:

Ashford	Bozrah	Brooklyn
Canterbury	Chaplin	Colchester
Columbia	Coventry	East Lyme
Eastford	Franklin	Griswold
Groton	Hampton	Killingly
Lebanon	Ledyard	Lisbon
Lyme	Mansfield	Montville
New London	North Stonington	Norwich
Old Lyme	Plainfield	Pomfret
Preston	Putnam	Salem
Scotland	Sprague	Sterling
Stonington	Thompson	Union
Voluntown	Waterford	Willington
Windham	Woodstock	

North Central Workforce Investment Area:

Andover	Avon	Berlin
Bloomfield	Bolton	Bristol
Burlington	Canton	East Granby
East Hartford	East Windsor	Ellington
Enfield	Farmington	Glastonbury
Granby	Hartford	Hebron
Manchester	Marlborough	New Britain
Newington	Plainville	Plymouth
Rocky Hill	Simsbury	Somers
South Windsor	Southington	Stafford
Suffield	Tolland	Vernon
West Hartford	Wethersfield	Windsor
Windsor Locks		

Northwest Workforce Investment Area:

Barkhamsted	Bethel	Bethlehem
Bridgewater	Brookfield	Canaan
Cheshire	Colebrook	Cornwall
Danbury	Goshen	Hartland
Harwinton	Kent	Litchfield
Middlebury	Morris	Naugatuck
New Fairfield	New Hartford	New Milford
Newtown	Norfolk	North Canaan
Prospect	Redding	Ridgefield

Roxbury	Salisbury	Sharon
Sherman	Southbury	Thomaston
Torrington	Warren	Washington
Waterbury	Watertown	Winchester
Wolcott	Woodbury	

South Central Workforce Investment Area:

Bethany	Branford	Chester
Clinton	Cromwell	Deep River
Durham	East Haddam	East Hampton
East Haven	Essex	Guilford
Haddam	Hamden	Killingworth
Madison	Meriden	Middlefield
Middletown	Milford	New Haven
North Branford	North Haven	Old Saybrook
Orange	Portland	Wallingford
West Haven	Westbrook	Woodbridge

Southwest Workforce Investment Area:

Ansonia	Beacon Falls	Bridgeport
Darien	Derby	Easton
Fairfield	Greenwich	Monroe
New Canaan	Norwalk	Oxford
Seymour	Shelton	Stamford
Stratford	Trumbull	Weston
Westport	Wilton	

Connecticut Public Higher Education
Undergraduate Tuition and Required Fees

	In-State			Out of State		
	FY2007	**FY2008**	**% Change**	**FY2007**	**FY2008**	**% Change**
University of Connecticut						
Commuter	$8,362	$8,842	5.7%	$21,562	$22,786	5.7%
Resident	$16,628	$17,692	6.4%	$29,828	$31,636	6.1%
Connecticut State University						
Commuter	$6,284	$6,736	7.2%	$14,606	$15,456	5.8%
Resident	$14,278	$15,189	6.4%	$22,600	$23,999	5.8%
Community Technic College System	$2,672	$2,828	5.8%	$7,976	$8,444	5.9%
Charter Oak State College						
Associate Degree	$920	$955	3.8%	$1,200	$1,235	2.9%
Bachelor Degree 1st year	$1,045	$1,070	2.4%	$1,360	$1,385	1.8%
Bachelor Degree greater than first year	$635	$655	3.1%	$845	$865	2.4%

Source: Board of Governors for Higher Education, Connecticut State Department of Higher Education, Connecticut Public Higher Education, 2007 System Trends, http://www.ctdhe.org/info/pdfs/2007/2007SystemTrends.pdf

Language Spoken at Home- Connecticut
2006

Subject	Total	Percent of specified language speakers	
		Speak English very well	Speak English Less than very well
Population 5 years and over	3,302,738	92.1%	7.9%
Speak only English	79.9%	N.A.	N.A.
Speak a language other than English	20.1%	60.5%	39.5%
Spanish or Spanish Creole	9.4%	57.8%	42.2%
Other Indo-European language	8.2%	63.1%	36.9%
Asian and Pacific Island Languages	1.9%	58.6%	41.4%
Other languages	0.6%	71.5%	28.5%

Source: U.S. Census Bureau, 2006 American Community Survey, Language Spoken Connecticut, www.census.gov.

Appendix 8 – Internet Access to Videotapes & Public Hearing

HealthFirst Connecticut Authority Public Hearings
Internet Access to Videotapes of Public Hearings

The HealthFirst Connecticut Authority held hearings around Connecticut between 9/17/08 and 10/6/08. The Authority wanted to hear the thoughts and concerns of Connecticut residents about the health care crisis. The videos below document the testimony at these hearings.

For more on the HealthFirst Authority, please go to http://www.cga.ct.gov/ph/HealthFirst/default.asp

For more on these videos or for corrections on titles, email pwessel@universalhealthct.org.

Clicking on the playlist links will bring a full screen version of the videos for that specific hearing.

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Putnam CT HealthFirst Authority Hearing 9/17/08

Putnam Playlist Link: http://blip.tv/play/gc5OAQA

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Norwalk CT HealthFirst Authority 9/18/08

Norwalk Playlist Link: http://blip.tv/play/ge1sAQA

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Torrington CT HealthFirst Authority Hearing 9/23/08

Torrington Playlist Link: http://blip.tv/play/gc5WAQA

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Wallingford CT HealthFirst Authority Hearing 9/24/08

Wallingford Playlist Link: http://blip.tv/play/gddaAQA

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Norwich CT HealthFirst Authority Hearing 9/25/08

Norwich Playlist link: http://blip.tv/play/gd8DAQA

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Waterbury CT HealthFirst Authority Hearing 10/1/08

Waterbury Playlist Link: http://blip.tv/play/ge1vAQA

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Hartford CT HealthFirst Authority Hearing 10/2/08

Hartford Playlist link: http://blip.tv/play/gd8CAQA

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Manchester CT HealthFirst Authority Hearing 10/3/08

Manchester Playlist Link: http://blip.tv/play/ge1tAQA

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Danbury CT HealthFirst Authority Hearing 10/6/08

Danbury Playlist Link: http://blip.tv/play/ge1rAQ

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Appendix 9 – Supplemental Comments

Supplemental comments submitted by Mike Critelli
c/o PITNEY BOWES INC.
ONE ELMCROFT ROAD
STAMFORD, CT 06926

February 27, 2009

Mr. Tom Swan
Ms. Margaret Flinter
Co-Chairs, HealthFirst Ct. Authority
Public Health Committee
Legislative Office Building, Room 3000
Hartford, CT 06106

Subject: Supplementary Comments on Final Report

Dear Tom and Margaret:

I want to commend both of you, your team, and the members of the various authorities and working groups for the heroic and high-quality work you all did to put together the report and its recommendations. We clearly have matured from a relatively narrow focus on health insurance, (which, while essential to comprehensive health care reform, is not sufficient) to a broader and more balanced focus on health improvement, health care delivery, and health insurance reform. You deserve a predominant share of the credit for steering the group, the discussion, and the report in this direction.

I also want to commend you for producing a report that, in its total architecture, addresses intelligently a broad range of critical health, health care, and insurance issues. I am proud and honored to have been a part of this process, and I thank you for the very productive dialogue you allowed all of us to have with you.

I have five comments that I would like to include as we furnish this report to our elected officials:

- While reform must be staged, health improvement and reforms in our health care delivery and payment systems must either precede, or be executed simultaneously with insurance reform. If we give everyone affordable insurance coverage, but do not address the other two issues, we will find that they will have insufficient access to quality providers and, over time, we will see declining population health and unsustainable cost increases. Health improvement and health care are foundational to universal, affordable health insurance.
- I appreciate the focus on value-based insurance and value-based health care in the report. I want to make sure that insurance reform not only includes insurance plan design changes that drive the right provider and plan participant behaviors to drive health and health care improvement, but also recognizes that insurance cannot pay equally for everything that medical providers might offer. Insurance mandates have been put into place over time and have added cost to every insurance policy, without a thoughtful re-examination of whether these mandates still make sense. An independent citizens' commission convened to assess the medical and

policy validity of mandates would make sense. While it is difficult to make value judgments among different medical conditions in terms of which ones require insurance coverage and which should be the responsibility of the individual, such value judgments must take place if we are to have an affordable insurance system.

- Getting comprehensive and high-quality data is critical. I want to underscore my support for those parts of the report that focus on electronic health records, aggregation of population-level data to assess whether we are getting good value for health care dollars, and the use of modern electronic technology for processes such as prescribing medication and lab tests.
- There is some potential for confusion in the report on the pooling issue. While the report is now clear that the Authority was unable to reach a consensus on pooling into the Connecticut Health Partnership, there are sections of the report which could be construed to be inconsistent with the broad direction of the report. It would be helpful to have you continue to clarify the intent of this language going forward as you did at our February 24 meeting.
- There is clearly a need for cost analysis relative to the report's recommendations. However, how that analysis is done is critical to whether the broad goals set forth in the report can be achieved. Any costing analysis that require no cost increases in a given year, and that neglects the notion that most good health expenditures will result in cost increases in the year they are made and cost reductions in future years, is flawed. A costing system that either ignores or discounts future year savings, even in this highly-constrained economic environment is doomed to delay implementation of many critical recommendations in this report. While the discipline of annual spending cap calculations must always be in place, it cannot be the only way in which investments in improvements in health and health care delivery are evaluated.

Having made these comments, I can say with great confidence that this report and those who worked together on it have taken the discussion on health care reform in Connecticut to a far higher level than when we started this process 18 months ago. I hope to play a constructive and continuing role in seeing this process through to a successful conclusion.

Thank you again for giving me the opportunity to submit these supplemental comments.

Very truly yours,

Michael J. Critelli

OFFICE OF THE LIEUTENANT GOVERNOR

March 3, 2009

Mr. Tom Swan, Co-Chair
Ms. Margaret Flinter, Co-Chair
HealthFirst Connecticut Authority
Public Health Committee
Legislative Office Building, Room 3000
Hartford, CT 06106

Dear Co-Chairs Swan and Flinter:

I would like to again thank you for your commitment and work invested in the HealthFirst Connecticut Authority (the "Authority"). Pursuant to the February 24, 2009, meeting please find my comments to be incorporated to the HealthFirst Connecticut Authority Report that was approved on that same date.

As I explained at the meeting, I could not vote in favor of the report for three main reasons:

1) The report did not contemplate the costs or any financial statistics of the recommendations contained within the report, as required by the enabling statute;

2) The report contained a vague recommendation about a pooling concept, which lacked details and a framework for such an idea; and

3) The report was admittedly incomplete and should have been postponed until the necessary details had been incorporated.

I understood that the Authority postponed the vote on this report in anticipation of financial data so that we could make an informed vote on the recommendations. Thus, I am confused as to why the vote occurred last week despite the lack of a cost analysis that was both promised and required by the statue that created the Authority. Mr. Swan indicated that the Authority may reconvene upon receipt of the financial analysis and possibly issue another report; a report that would be a more complete version that the one that was voted upon last week.

I am disappointed that the Authority could not submit a report that contained a set of recommendations that the entire Authority agreed upon. As I stated to you in my January 9, 2009

letter, I felt that the draft report had many positive aspects and several proposals upon which the entire Authority could have reached a consensus. It was my hope that the Authority could have presented those unified recommendations to the General Assembly and the Governor so they could act upon them this session. I remain committed to working diligently to improve the quality of health care for Connecticut residents and am willing to participate in any further deliberations this Authority may conduct.

Sincerely,

Michael Fedele

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Supplemental comments submitted by Mickey Herbert
February 25, 2008

Comments on the Final HealthFirst Connecticut Authority Report
Health Insurance Representative Mickey Herbert
President and CEO of ConnectiCare

"Never let the perfect be the enemy of the good" typifies my feelings about my vote in support of the HealthFirst Connecticut Authority report. The latest draft of this report was approved by the Authority in an 8-2 vote of its members.

Although I voted in support of the report, there continues to be parts of the report that I do not support and they are outlined in this letter. Most notably, the report recommended that all Connecticut residents be given the opportunity to "access coverage via a health insurance pool with group protections, whether public or private." Nowhere in the report is there a discussion of how such a pool (or pools) would actually function, and in fact, the report explicitly does not recommend the state employees' health plan as such a pool. With all the discussion over the past year about "pooling", it is inconceivable that this report would recommend some form of pooling without any explanation as to what that actually meant.

Moreover, as I expressed in the meeting, I have a major concern now that the report's rather indistinct and benign endorsement of a pooling concept will overshadow the many more substantive recommendations in the report. I even have a concern that proponents of opening up the state employees' plan to small businesses and municipalities will now claim that the HealthFirst Connecticut Authority has endorsed such an opening, even though the report clearly says that there was no consensus on this issue.

Another fundamental weakness of the report was the lack of financial data as to what any of the recommendations might cost. At today' Authority meeting, there was an explicit acknowledgement of this lack of financial data, along with a statement from Co-Chair Thomas Swan that this financial data would be forthcoming at some time in the not-too-distant future, at which time the Authority might reconvene to reassess the vote that we took this morning. Thus, the members were being asked to vote in support of recommendations that might (and, in some cases, clearly will be) beyond the state's financial capacity to support, but we will not know that for sure unless and until the report is amended with key financial data that might or might not be forthcoming. On this point alone, it is completely understandable that the Lieutenant Governor and the Chief Executive Officer of Stamford Hospital felt they could not vote in favor of the report.

It was also disappointing to me that that the final report did not contain a recommendation in support of an effective, enforceable, individual mandate that all Connecticut residents obtain health coverage. The report did recommend that "serious consideration… be given to the issue of an individual mandate as the health reform process moves forward in Connecticut…" The report should not have equivocated here, but should have actually recommended the individual mandate. Such a mandate clears the fastest

path toward universal access, and I look upon this omission as a true missed opportunity on the part of the Authority.

Despite these three problems in the report, I was unwilling to see the extraordinary efforts of the report's scribe, Co-Chair Margaret Flinter, to reach a consensus to be in vain. In many respects, this report embodies many of the same recommendations contained in the Connecticut Health Insurance Policy Council report that was developed in 2006 and presented to the state legislature in January 2007. I was the Co-Chair of that council, and I have been eager to advance the policy framework contained in that report.

Thus, I voted in support of the report despite the three substantive reservations I have expressed above. It is my sincere hope that all three of these reservations will be addressed by the administration and the legislature, as the debate on health care reform in Connecticut continues. Also, I believe the Legislature would be best suited to focus on the parts of this report that do have full consensus in choosing their efforts to implement.

I have also included below my comments on the Authority's report that I submitted to Co-Chair Margaret Flinter immediately after the first final draft of the report was submitted to the Authority on December 17, 2008. I believe my comments submitted in December are still germane to the final report.

I look forward to working with the Legislature and the members of this Authority going forward to build consensus on the many state health reform proposals. I believe achieving consensus and buy-in from the major players involved in the health system is necessary for successful, sustainable reform. I remain committed to finding a way to provide universal coverage to all citizens in the state that is both affordable and produces high quality outcomes.

Health Insurance Representative Mickey Herbert's Comments on the HealthFirst Connecticut Authority's Final Draft Report as of December 17, 2008

Most of you in this room know that I have been working to realize the goals of this Authority for the past 2 ½ years:

- The first twelve months of that time with a private, non-profit entity called the **CT Health Insurance Policy Council**, which I founded with my co-chair, **Bob Patricelli**; and
- For the past year and a half with this Authority as the representative of the health insurance industry.

Over the course of this 2 ½ years, I believe we have made genuine progress toward reaching a consensus among key stakeholder groups as to how to effect genuine health care reform in the state of Connecticut. I believe that this draft is, in some respects, a testament to how far we have come in reaching that consensus, even though in this room we have groups and organizations with widely different interests and concerns about our health care system.

It is interesting to me that in the introduction of this draft that it states that the report **"does not provide a blueprint for reform,"** but rather a **"roadmap that identifies areas for further work and principles to help guide decision making further down the road."** When we completed our Policy Council Report we entitled it, **"A Framework for Health Care Reform for Connecticut"** because we too did not feel we could or should lay down a complete blueprint for our legislators.

So I do feel that after 2 ½ years that we are gaining consensus on how to achieve healthcare reform, and we're slowly but surely moving the ball down the field.

Having said that, I need you to know that, as a voting member of this Authority, I do have some distinct problems with this draft, and I will be providing the members of the Authority with a description of these problems.

Let me briefly mention some of the problems as I see them:

There is rather confusing language in the report with regard to adverse selection, risk-adjusting premiums, crowd-out pressures and the like. Moreover, the report seems to advocate for banning pre-existing exclusion provisions and favoring pure community rating in the setting of health insurance premiums. Let me just say that this is a critical area for future study, and one in which the health insurance industry has only recently concluded that in order to make affordable coverage available to everyone, then everyone must participate by having some form of health care coverage. Only with an **effective enforceable individual mandate** can insurers accept all comers and still provide that coverage at an affordable price. Even then, there will be many who still cannot afford that coverage and we will need government subsidies of some sort to enable these individuals to purchase coverage. And yet this draft rejects the notion of an effective, enforceable individual mandate.

Another area of major concern to me is the notion of the legislature passing **minimum medical loss ratio legislation** on health insurers as a means to control health care costs. Though the draft does not recommend that this happen, it is listed as an initiative that is **"perceived to focus directly on the cost of health coverage."** There is also a statement made in the draft that **"reducing non-health care spending could reduce premiums."** I would forcefully point out that the opposite may be true. That is, if health plans are forced to reduce their value-added administrative activities such as **network contracting, wellness and prevention, disease management or utilization review activities**, health care costs may indeed increase precipitously. I am not aware of any other state in the country that has enacted minimum medical loss ratio legislation on group health insurance. It is simply ill-advised and any reference to it should **not** appear in the report. The last thing we want to do is needlessly render damage on a health insurance industry which represents 22,000 direct jobs in this state and another 15,000 jobs indirectly.

The final area of concern I'd like to mention has to do with what the draft refers to as the **"implementing entity"** in Connecticut for health care reform. Although the draft discusses this entity under a section entitled **"options"** and makes no recommendation at this time, there is plenty of **"should"** language in this section which certainly seems to advocate for a new quasi-public entity with

accountability to the legislature. And the final sentence of the draft says that final decisions on the initiatives discussed in this roadmap **"be made by the implementing entity."**

As I have said in the past, my concern is that we not create another large state agency to oversee the many state agencies that currently have responsibility for state-sponsored health programs.

I applaud the drafters of this report for moving the whole notion of the creation of a new quasi-public trust from what appeared to be a strong recommendation, to something that might "evolve over time as need and opportunity present."

Lastly, I think it is critical that we continue to emphasize, as has been mentioned in this draft, two critical items:

1. We don't yet know the full dimensions of the current economic crisis, although it is already apparent that our state government will be severely challenged to meet its existing and future obligations, including a $22 billion unfunded retiree medical liability for its employees; and

2. There will be some very meaningful health care reform proposals emanating from Washington, D.C. I am actively engaged with our national health insurance association in working on matters of federal health reform, along with the CEOs of Aetna, Cigna, HealthNet, United and the Blues, and just last Friday we met with the Congressional staffs of Senator Ted Kennedy and Senator Max Baucus. Suffice it to say that federal health care reform is "top of the mind" in Washington. And I think we need to be especially wary of advocating for any state reforms that are not entirely consistent with what will be coming out of Washington.

In addition to my general remarks above, I would also like to submit some more specifics remarks about the final draft of this report.

The report should not advocate for using the state employees' health benefit plan as the template for reaching universally available, affordable comprehensive coverage. This is one pool that is simply far too rich and far too expensive to serve that function. Moreover, it is not necessary or desirable for every state resident to have "the pool" as a choice, especially if he or she already has employer-sponsored insurance. Good risks will choose the best deal, so if the pool is rigged with different rules than the private market, one or the other will likely over time to experience a death spiral. The report claims that "crowding out" needs to be scrupulously avoided, but you actually encourage crowding out with universal dual choice. The report's objective to "maintain and build on employer-sponsored insurance" can hardly be met if individuals and employers can choose another option at will.

On page 8, I disagree with this sentence in the fourth paragraph: "There are seldom good evidence bases for making effective decisions on care and coverage, and neither practitioners nor patients nor insurance consumers, are well motivated to make value-based decisions or to engage in systematic prevention of illness." Insurers do have evidence-based decision tools for coverage parameters -- people just don't like to hear that their request doesn't fit them. And why would one suppose that no

one wants to prevent illness, even doctors and patients? The will to make people healthier is out there. Different factions disagree on the preferred methods.

The next paragraph on page 8 talks about affordability being key, but then contemplates that the state employee plan be utilized as a "piggyback" "mainly at the upper end, although ultimately to be opened to all". As stated above, the state employees' benefit plan is far too rich and expensive to be considered as a template to make health care more affordable.

On page 10, in the third full paragraph, there is reference to how insured individuals would be attracted to "reform coverage that features community rating, particularly individuals or families that are now paying high rates because of age or health history". This sentence ignores the fact that in such an environment, rates will go up rapidly and the healthy will have a strong incentive to find cheaper options. You cannot have guaranteed issue and community rating without an individual mandate. It has been tried in eight other states and it has worked nowhere.

Pages 11 and 12 discuss how cost-sharing causes financial instability. In some cases, that is certainly true. But what does "affordable coverage" really mean? If premiums are low and benefits are especially generous, who will underwrite the losses incurred in such a scenario? And isn't it true that consumer cost-sharing can assist in reducing unnecessary utilization by making consumers more aware of their health care expenses?

On page 18, the "Technology" section is confusing. We are paying more for health care, but that does not mean that we aren't always getting more. Some prices rise for the same level of care, and sometimes we pay more for inefficient or ineffective care. These questions are critical to affordability, but would involve rules about when technologies could be used. And, of course, that's not popular with physicians.

The report often references "value-based" coverage, care or benefit design, but never really defines what is meant by this phrase. There needs to be a succinct and clear definition of what is meant by "value-based" included in the report.

Page 27 has many assumptions about how a pool would work, with no evidence to back up those assumptions. Success is assumed because of size alone. It sounds like the "partnership" would buy coverage from private plans, which will take the risk. And the report suggests premium withholds, because it is not possible to know in advance what risks each plan will get. They would measure the risk by drug usage, for some reason. And plans would be punished if they don't behave the way the pool administrator wants. How can a carrier provide coverage for less than full premium? How could coverage be affordable with rich benefits and low premium contributions? Clearly, no effort was made to analyze how this would work in the real world.

Also on page 27, under "Enrollment", there's a stated preference to put everyone who's eligible for a public program into the public program and have them opt out of employer-sponsored insurance where available. Isn't this backwards? Shouldn't the goal to be to encourage private coverage where possible,

with subsidies where appropriate?? This accomplishes “crowd out”, rather than avoiding it. The paragraph under "Financing" shows nothing that will improve access to affordable employer-sponsored insurance. Affordability has not been addressed at all, in fact.

I am not sure why the report contains the lengthy paragraph on page 34 regarding the “public role in private provision of care”. It reads like a manifesto for the government to intervene aggressively in the private insurance market. Just not necessary.

On page 35, there is a reference to the state being “shovel-ready” when new federal legislation or regulation is passed. Health care reform is not like building a bridge. There's no way to know whether a particular idea will fit in with the federal government’s ultimate rules. If the report’s recommendations were to all be followed, it seems everyone will have access to Charter Oak and the state employee pool, and we will have changed insurance regulation and the health care delivery system in some unspecified way to achieve the goal of getting everyone possible into a public plan. It's irresponsible to recommend that without some real analysis of how the finances would work.

Though I have already expressed my concerns about the “implementing entity” discussed in the report, I am still upset about the paragraph on page 36 entitled “recommended characteristics of responsible entity”. There is an inherent assumption in this paragraph that the “responsible entity” could do wonders just by taking all the problems on to itself, with no explanation as to how this would work. The Summary and Conclusion (pp 37-38) is “Let’s just do it!” Even though it is clearly acknowledged that we simply do not have anywhere near the data we need to discern how we are going to do it. Without that discerning ability, we may simply be wasting money and resources.

Thank you for the opportunity to offer these comments on the HealthFirst Connecticut Authority final draft report.

Supplemental comments submitted by Sal Luciano

"I'm on the Highway to Health… or hell?"

Apologies to the rock band AC/DC but I am trying to make a point that not all infrastructures are made of concrete and mortar and steel.

Two years ago, the Authority could not have known that we would have a health reform candidate such as Barak Obama elected President or the financial crisis we find ourselves in. Barak Obama is planning to help fund an infrastructure for Health Care.

The Health First report does a good job of laying out what that infrastructure might look like.

One of the infrastructure recommendations are made out of electrons: a secure web based electronic medical health record. This is projected to save 15% of health care costs from efficiencies, avoidance of duplication and red flags on such problems as pharmaceutical drugs that taken in combination are poisonous. Those that would maintain the infrastructure could be those that lose some of the billing jobs lost when pooling and other efficiencies are put in place.

The other infrastructure recommendation is to acknowledge that an emergency room visit is the personal equivalent of a bridge collapsing. It is where the greatest costs are by far and where we see the foolishness and short-sightedness of not having a real plan regarding health care.

It is in recognizing that the focus should be first on preventing chronic health problems and simultaneously treating chronic health care problems that is one of the real strength of the report. It does better than just saving money, it improves outcomes.

The idea that everyone has a medical home that has responsibility for preventative and age appropriate screenings that save dollars and improve health is one of the key components to the infrastructure around which everything else depends. We need primary physicians who have time to ask why someone can't sleep instead of just prescribing a pill. And we need to have incentives so that we have enough primary health physicians to get this done.

You can't have a highway without police. Kevin Lembo, the Health Care Advocate was an integral resource, not only to the Authority but in advocating for people that had health care problems with their insurer. He not only helped them with a significant amount of personal costs both reimbursed and appealed and approved, he also helped them get health procedures they needed.

Lastly, there is the bridge to affordable health care for municipalities.
Opening up the State Health Care pool is not a new concept. Half of the other states in this country have already done this.
In CT, small businesses support it, the Heritage foundation heralds it, labor leaders push for it, non-profits need it, consumer advocates recommend it and when David Osborne, the writer of, The Price of

Government and consultant the Governor brought to speak last month calls for it. Government controlled spending on Health Care, for State employees, municipal employees, Medicaid and Medicare is about 25% of all health Care spending.
They could and would be leveraging that money in the most efficient and cost effective way.
State employees are not young. They average close to 50 years old.
State employees are not healthy. Twenty percent work as Correction Officers in the prisons and jails in one of the highest premature mortality jobs in this country.
Despite the fact that we are neither young nor healthy, we have been able to get lower costs for health insurance and more importantly, keep them lower.

The fact is that the benefit of a large pool is not some academic musing; it is not theoretical; the actual State of CT rates for a single for both the POE and POS plans were $4, 600 and $5,800 respectively. For family coverage on the POE and POS plans it was $15,000 and $15,800 respectively.
These were the rates for both July 1 '07 and July 1 '08. Health Care costs for state employees went up zero % last year. Compare that to many municipalities that pay more than $8,000 for individual coverage and more than $20, 000 for family coverage; often much more than $20,000 for family coverage.
Health Care for all is more important now than it has ever been. While employer sponsored health care was and remains a cornerstone for providing health insurance, the present crisis and rising unemployment shows just how tenuous employer coverage is.

Thanks to all my colleagues and others who participated on the Health First Authority.