HealthFirst Connecticut Authority

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Cost, Cost Containment and Finance Workgroup

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

Margaret Flinter, Tom Swan, Yvette Highsmith-Francis, Lou Brady, Sanford Herman, Michael Hudson, Lou Brady, Leo Canty, Margaret Flinter, Art Tanner, Sheldon Toubman, Connie Razza, Victoria Veltri, John O'Connell, Paul Grady, Jill Zorn, Bob Rinker, Paul Lombardo, Robert Tessier, John Farrell, Rick Larose, John Harrity, Paul Filson, Andrew Gold, Karl Ideman, Sal Lucciano,

Also present were: Eric George representing John Rathgeber, Steve Jewitt representing Mickey Herbert, and Joe Hero representing Sharon Langer, and Rich Sivel.

Margaret Flinter introduced members to the Workgroup meeting and introduced John J. Farrell.

John J. Farrell offered a presentation on the availability and use of health care data. He explained that in the insurance business, data was contained by different groups. Major health insurers have been compiling data and making that data web based to make it more accessible and easy to use. Most payers have paper-based files. He explained that he worked with claim-based data primarily. Health risk assessment, critical lab and electronic medical record data has been added recently.

The objective is to coordinate care management by using physician hospital collaborations, and participation in commercial medical management programs.

California State Employee Retirement System (CalPERS) has 1.5 million employees and has been working on a health systems technology as a way of expanding a knowledge base.

In the traditional process the employer pays a premium and the payer is involved in the care management process. In the CalPERS process, another firm is interjected for analytical information and advice.

Historically there have been limitations to technology advance. The disparity and incomparability of data has been one limitation. The size of databases, excessively long, complex and costly analysis, security and portability has also impeded the expansion of technology advances. Data must not only be categorized in the same healthcare system, but it must be comparable and compatible. Data systems are currently being created to support these functions. Predictive models are being added to databases as a way to predict illness and impact the cost curve.

The amount and repetitive way of collecting data has impeded the expanse of data. Maintaining the security of data is much easier than it has been in the past.

The typical sources of data available today are medical claim and prescription data. Evolving sources of data include health risk assessment, clinical lab and electronic medical record data.

John Farrell presented an online example of stored health information and its accessibility. Health information stored online allows healthcare providers to easily access and compare a large database of health records. Electronic healthcare data allows care providers to access information and answer questions in seconds where it may have taken weeks in the past.

John Farrell offered a comparison of the largest US population based data warehouses.

The HUSKY program and the State Employee program both could provide the State of Connecticut with statewide data sources.

In Connecticut, there has been a massive consolidation of payers.

Margaret Flinter asked if it would be possible to take the state employee claims data database and predict what Connecticut is likely to spend in the next 5-10 years on chronic disease if we make no changes to the way chronic care is performed.

John Farrell responded that the technology has advanced so rapidly that the analytical skills are lagging behind. However, it would probably be possible to make that prediction.

Margaret Flinter asked if there was an applicability of the technology to the provider office or the community health center office where they would be able to look at their own population with specificity and sort out the people that need more attention without having to wait for the insurer to tell them who those people are.

John Farrell responded that would be possible and is already being done in Connecticut.

Paul Lombardo asked how it is possible to deal with the trust issue between the provider and employer groups regarding data.

John Farrell responded that physicians are paid different rates and some offer conflicting opinions of what is listed in the database and what their client is experiencing. Each case should be dealt with separately.

Steve Jewitt asked if there were other states that use state-wide data system that Connecticut could use as an example.

John Farrell responded that CalPERS is the best data system available.

Victoria Veltri asked who accounts for the accuracy of the claims data that goes into the system and also asked if the system accounts for plan design differences.

John Farrell responded that if data isn't coded properly there could be a problem. Data is checked regularly, but if it entered in the system incorrectly it can cause problems.

John Farrell explained that part of the process is understanding who the uninsured are. This tool helps make sure there is access to care.

Jill Zorn asked how a state like Connecticut receives data on self-insured plans.

John Farrell responded that legislative action is needed to accomplish that.

Margaret Flinter asked about the risk assessment of the individual and predictive modeling of risk assessment.

John Farrell explained that the health risk assessment is not used frequently for risk adjustment but claims data often is. It would not be used as the sole determinant. Likelihood of hospitalization models is being used more frequently.

Margaret Flinter asked about electronic health records at the point of providing care.

John Farrell explained that we now have claims data so that is not the problem.

Bob Rinker asked if all information would reside in all databases.

John Farrell responded that was not the case and depends on what the state has contractually agreed to do.

Bob Rinker asked about a bill on pooling currently being debated in the State Legislature. The argument in favor of the bill is that pooling could have an effect on the state employee pooling data.

John Farrell suggested that the State should put in place a system that prices healthcare resources properly and be able to assess prices in the future.

Bob Rinker asked about premium dollars and the amount paid to providers.

John Farrell explained that it would be possible to track all transactions.

Tom Swan asked John Farrell for advice on policy recommendations to the Legislature.

John Farrell suggested that fears that the system would be misused would need to subside. The locations of the information would need to be determined and examined. There also must be collaboration with large payers.

Leo Canty explained that on a policy level there is not a commitment to gathering data for the purposes of creating an electronic system. Leo Canty asked what other barriers there have been in creating a public policy around an electronic healthcare data system.

John Farrell suggested that the best thing the Legislature can do is show value in the process.

Leo Canty explained that if data is available, it is possible to create a system of prevention that deals more directly with certain ethnic and racial groups that may need enhanced care.

Victoria Veltri asked if the data systems are for sale.

John Farrell responded that they were.

Paul Lombardo explained that the use of the data may be interpreted in different ways. There would need to be standards of how the data would be viewed so that people could be comfortable that data is not misused.

John Farrell explained that the federal government has already started working on systems that insures that data is interpreted properly.

John Farrell explained that there is a set of standards out there and that level of scrutiny has not been reached.

Eric George asked if the collection and analyzing of cost data is more advanced than the collection and analyzing of quality data.

John Farrell responded that it was. The quality side is easier to interpret.

Eric George expressed his feeling that it is paramount to move forward on the quality side and asked what the obstacles to moving forward are.

John Farrell explained that the limits have to do with the constraints of coding information.

The meeting minutes from the April 11th, 2008 Cost, Cost Containment and Finance Meeting were approved.

Margaret Flinter gave an update of recent Workgroup and Authority meetings. The Quality Access and Safety Workgroup focused on health disparities in Connecticut as well as workforce issues.

Tom Swan offered a presentation of health care options that had been discussed by the HealthFirst Authority:

1. Universal entitlement to primary care or coverage, with insurance purchased for inpatient care only.

Example:	New program offered by the state.
Design:	Primary care provided by or paid for by the state. Non-primary care subject to separate traditional insurance.

Target: All state residents or legal residents; or uninsured residents only.
Experience: None in this country.
Design questions: What to include as primary care?

2. Regionally organized networks of care (possibly building on / extending Charter Oak).

Example: Individuals without private insurance could buy into new coverage plan, state required to subsidize needy.
Design: New offering of affordable coverage for currently uninsured adults and children with premiums, co pays, and deductibles; affordability based on sliding scale. Regional organization of care including at a minimum, an acute care facility, an FQHC, and a network of private primary providers and specialists to facilitate quality and efficiency.
Target: Uninsured adults and children.
Experience: Combines elements of reforms in San Francisco and North Carolina.
Design questions: Mandatory or voluntary participation, allowance for out of network care.

3. Insurance-Choice System.

Examples: Make state employees' plan available to all, other pooling mechanisms, buy-in to public programs could make Husky/Medicaid a new choice for residents.
Design: Establish a new entity or use an existing entity to purchase coverage collectively on behalf of participating employers. Would negotiate contracts with a variety of health plans, as large employers do, allow individual employees to choose among all participating health plans. Many variations possible in plan of operations.
Target: Employers to increase offer rate of insurance to employees; employees to improve choice of plans.
Experience: A significant minority of states have tried pools. Health plans resist participation, which is seen as competing against their own non-pool offerings. All existing pools are small. WV has opened aspects of the state employees plan to small business.

4. Bolstered Employment-Based system.

Examples: Employer mandate, state subsidies for low income and/or high risk, liability/regulatory reform, mandatory reinsurance with or without state financial participation, tax incentives for employers.
Target: Employed residents and (possibly) their dependents.
Experience: Hawaii for mandate. Regulatory reform alone has shown little impact on coverage in other states.
Design questions: What qualifies as coverage, who qualifies as employer, offer vs take-up, dependent coverage.

5. Universal entitlement to publicly financed coverage.

Examples: Single payer/single plan, state self-insurance with plan choice
Target: All residents or all resident citizens.

Experience:	None in this country but universal coverage is the norm in other highly developed countries.
Design questions:	Single plan vs. choice of plans, public administration or ASO arrangement, mechanism for enrollment, response to non-enrollment, eligibility of non-citizens, benefits, how to address any remaining uncompensated care by non-eligibles.

Tom Swan explained that as a workgroup there would need to do more investigation into financing mechanisms depending on the healthcare options that are selected.

Margaret Flinter offered the Workgroup an opportunity to discuss the healthcare options.

Jill Zorn asked if the selection process may include a combination of elements of different plans.

Margaret Flinter suggested it could be a combination of plans.

Steve Jewitt expressed his feeling that data elements may be helpful. These include who the uninsured are and what information we have about them. Common agreement on who the uninsured are may be necessary. We have 24 billion dollars in healthcare expenditure and we need to know which age groups consume the majority of that money. We need to know the value of Connecticut payrolls. The value of mandated benefits would be helpful. Massachusetts was successful because of federal matching funds and we need to investigate how those funds work. The value of expenditures on uncompensated care would be useful. The hospital task force has good data from hospitals on uncompensated care. The state employees healthcare plan should be investigated on a per member basis and we need to find out what the plan actually costs. What is the claim cost of the plan. A developing concept is the health risk cost. We may want to explore that concept. There should be common understanding on what small group markets in Connecticut are. At some point there should be agreement on what a minimum benefit plan is. We need to project a cost per person on providing healthcare.

Connie Razza asked suggested that the workforce shortage solution should be considered a cost item.

Art Tanner explained that the mission of dealing with the uninsured and the issue of fixing the healthcare problems in Connecticut are two different missions. The Workgroup must make a decision on what their intent is with regard to systems change.

Margaret Flinter responded that the legislation asked for the Workgroup to achieve both of those goals.

Eric George asked if comments on the healthcare options should be sent by e-mail.

Margaret Flinter explained that comments would be sent to Randy Bobvjerg and Barbara Ormond of the Urban Institute.

Eric George expressed a belief that some of the healthcare options are limited with regard to their focus. The employer sponsored option seems to be limited in this way. An employer mandated system would limit the focus of cost, quality, and the cost of insurance through mandated benefits.

Tom Swan agreed that those were some of the concerns with the insurance policy council.

Paul Lombardo explained that the Workgroup has not defined what "under-insured," means. It needs to be defined as Workgroup and the Authorities develop a healthcare plan.

Margaret Flinter Agreed that was a concern that needs to be considered.

Victoria Veltri expressed her position that the Workgroup needs to come to agreement on certain issues. She raised the possibility of workgroups coming together to come to agreement.

Margaret Flinter explained that the size of the Workgroups makes a joint meeting difficult, but that the two groups need to find a way to share ideas and come to agreements on the direction of the Workgroups.

Sheldon Toubman asked if the Workgroup was intending to cover the uninsured or reforming a broken system. Many experts seem to think we can't do both. Some say Massachusetts has done both but others seem to think that the system in Massachusetts is unsustainable.

Leo Canty suggested the focus of the workgroups should be on issues that most members can find commonality on. Perhaps the Workgroup could include disease management and chronic care management in that focus.

Margaret Flinter suggested that some of that work has been done in the areas of electronic health records, focus on smoking and obesity, and chronic disease management.

Jill Zorn asked if there was a way to get all of the information that had been sent to other Workgroups and Authorities.

Margaret Flinter responded that all of that information was available online at the HealthFirst Authority web site.

Yvette Highsmith-Francis asked for assurance that dental and behavioral health services would be included when addressing costs.

John Harrity made note that in some of the presentations that have been given of healthcare plans in other states, money that the state was already spending was diverted to other programs. That type of breakthrough has not been made in Connecticut yet.

Sheldon Toubman asked about the financing of end of life care. A lot of the dollars in the system are spent on end of life care. There may be too much funding in end of life care.

Margaret Flinter explained that in end of life issue a lot of work has recently been done.

John Harrity explained that one of the overlaps between the two groups is a group on evidence based health. Cost savings may come from that group, but we must work with that group directly to

understand what that impact may be. Without fundamental design change you will not see an improvement in health.

Art Tanner discussed the issue of capacity. If patients are added to a system, there must be facilities and staff that can handle them.

Tom Swan announced the next meeting of the HF AND PCAA meeting on May 14th. The next HF meeting is May 29th at 9:00 AM in Room 1C of the LOB.

The meeting was adjourned at 10:55 AM.