DRAFT

Delivered to the Connecticut Healthcare Reform Advisory Board May 27, 2010

In several meetings, I have made the comment that it will not be enough to define healthcare reform as getting people insured. It is more than that. It is getting people access and most importantly, it is improving the health status of the community.

The goal of national reform, as it is specifically applied in CT, is to take 334,200 estimated uninsured and place them in 3 categories:

- 52% will have commercial insurance offered through a new Exchange= 173,784
- 14% will join the ranks of Medicaid =46,788
    - (With adding SAGA, the Medicaid population will be almost a half million people)
- 35% will remain uninsured – illegal 116,970

These numbers will only occur if enrollment information is properly disseminated. Then, if enrollment actually occurs, people in these categories will place specific stresses on the system.

1. How will we care for illegal aliens?
    a. Currently unanswered.
2. Will Medicaid recipients have access?
    a. Current enrollees do not have access so future enrollees will not have access.
    b. Consider gradual increases in provider reimbursement based on the number of patients a doctor sees.
    c. Consider other incentives to get physicians to participate. "If this, then that"
3. The people newly enrolled in commercial plans will likely buy affordable plans that are accompanied by high deductibles. In this environment, insurance companies receive their premiums, patients receive access with their ID cards and <u>every</u> doctor's office will be faced with collecting deductibles. In the back office of every doctor is a collection agency that is doing work that is time consuming, duplicative and expensive. Many physician offices have resorted to collecting deductibles upfront, to be sure they get paid. If a person can't pay their portion, access may still be a problem.
    a. Relieve physician offices of the deductible burden by having the insurance companies collect it. They already collect premiums and already define the deductible.
    b. Provide interest bearing loans to those who must finance all or part of their illness.
    c. Allow physicians to give free care or reduced rates to needy patients, at their discretion, since this is currently prohibited. There are many doctors with charitable philosophies, who can't provide discounts to the needy because of the requirement to bill all patients equally.
    d. Define consequences for enrollees when they do not meet their obligations. The current consequence is the patient is sent to collections and a credit reporting agency.
    e. Review collection laws, as they pertain to physician offices.
4. An overarching concern for all these categories is that the state's fiscal health is very poor due in part to a budget based upon borrowing. Therefore it is anticipated that health reform programs may underperform if not self supporting and solvent.

An important reminder is that the entire Healthcare Reform platform is completely voluntary from a physician standpoint.

    a. Develop concrete incentives to encourage primary care physicians to practice in the state.
    b. Develop incentives to encourage physicians to participate with certain payers.

By focusing tremendous efforts on Tobacco, Food, Inactivity and Stress we will truly improve the health status of the community. We cannot reform the system until the system focuses upon health maintenance and preventative medicine, instead of treatment of disease.

    a. Implement the CT Health Improvement Advisory Board

Thank you,

Cathy Bartell, MHA