CT Health Care Reform Advisory Board

Minutes of January 26, 2010 Meeting

Members Present: Deputy Commissioner Cristine Vogel (Chair), Department of Public Health (DPH); Cathy Bartell, MHA; Alexandra Thomas, Aetna; Christopher Dadlez, Saint Francis Hospital and Medical Center; Robert Dakers, Office of Policy and Management (OPM); Commissioner Thomas Sullivan, State Insurance Department (SID); Carole Noujaim; Mark Schaefer, Department of Social Services (DSS); Rick Willard, Leadership Council of the National Federation of Independent Businesses; Lenny Winkler, LPN; Tom Woodruff, Office of the State Comptroller.

Member Absent: Commissioner Robert Galvin, M.D., M.P.H., M.B.A.; James Cox-Chapman, M.D., ProHealth Physicians, MSO, Inc.

Review and Approval of Minutes

Deputy Commissioner Cristine Vogel called the meeting to order at 10:00 AM.

A motion was made to accept the minutes of the January 7, 2010 Advisory Board meeting. The motion was seconded and passed unanimously by the Advisory Board members.

Discussion of Draft Guiding Principles

Led by Deputy Commissioner Vogel, Advisory Board members discussed the draft guiding principles. The guiding principles were submitted by the Board members and organized by topic. Guiding principles were defined as broad, high level principles that can guide consideration and implementation of health care reform. Items submitted by Board members that fell into the category of a recommendation (targeted, measurable and action oriented) rather than a guiding principle are being held until the time that the Board considers the development of specific recommendations. Although the federal health care reform is stalled, the two federal bills are still in play and the principles may be useful to help Connecticut influence the final federal health care reform legislation.

Below are the draft Guiding Principles presented to the Advisory Board for discussion.

A. General Guiding Principles

1. Access to health care is beyond having insurance and Connecticut must seriously address the issues that create a barrier to access such as: lack of primary care providers, facilities open after 5:00 pm, simplification of the administrative processes, etc.

2. Encourage the Board that is charged with health information technology and information exchange to move forward aggressively so cost-containment efforts can be achieved.

3. Carefully review the impact that employer penalty mandates have on large employers and that the insurance reforms (i.e., rating rules) have on small employers.

4. Support a process that allows a smooth transition for large and small employers as they adopt the new mandates.

5. Consumer education is necessary for the individual mandate and the purchasing exchange to be successful.

B. Individual mandate

1. If there is going to be a healthy market with guarantee issue and the elimination of pre-existing condition exclusions there must be a strong individual mandate with appropriate income sensitive subsidies in order for the coverage to be affordable. Creating one pool will reduce the potential for anti-selection. In addition, allowing individuals to only enroll and dis-enroll on an annual basis will reduce anti-selection.

2. Set the penalty for non insurance coverage high and use penalty money exclusively to fund the 90 Community Health Centers, 30 acute care hospitals, and providers who have formally agreed to accept uninsured and government programs.

3. The Individual mandate should provide sufficient penalties for remaining uninsured coupled with sufficient subsidies for lower income individuals and families to ensure that everyone has access to reasonably priced insurance coverage resulting in most of the uninsured choosing to participate.

C. Purchasing exchange

1. The Exchange should take the form of a competitive model to facilitate consumer choice, competition and cost-efficiency, by providing sufficient consumer-friendly information; allowing participation of plans that meet the Exchange criteria; allowing sale of coverage outside of the Exchange; and not duplicating existing regulatory functions.

2. An Exchange should have a governance board that includes all stakeholders, does not duplicate existing government functions and has some flexibility in the context of well defined objectives. The main purpose of the governance board should be implementing federal Exchange requirements.

3. States have consumer protections in place (solvency standards, rate review, fraud prevention, patient/consumer protection), that should not be preempted by federal reform.

We would strongly recommend that the regulation and oversight of the "Exchanges" discussed in both Federal bills be regulated by the states.

4. Should an exchange be agreed upon, a website (similar to that currently in Massachusetts) should be set-up that would include the options, along with a calculator that the consumer can populate in order to determine what their best option is.

5. Ensure that the eligibility system utilized at DSS interfaces with the system used for the purchasing exchange.

D. Expansion of the Medicaid program

1. The State of Connecticut should closely monitor the federal reform legislation and the related regulations and guidelines in order to ensure that the provisions with respect to the Medicaid and Medicare are equitable in terms of their impact on the State and its health care providers, as well as to prepare the State to undertake any implementation responsibilities it will have with respect to the changes in these programs.

2. Lower the cost shift to private insurers of the Medicaid shortfall by maximizing federal matching payments to the Medicaid program by adjusting the Medicaid rates to the true hospital cost for the delivery of care and building in an annual market rate adjustment to Medicaid rates based upon the annual Medicare market basket increase.

3. Support inclusion of State Administered General Assistance (SAGA) program patients in the Medicaid program at the earliest feasible moment either through the new federal reform legislation or through a federal waiver to the existing Connecticut Medicaid program.

4. Review and consider each proposal that maximizes cost sharing.

5. Support opportunities to improve Long Term Care (funding & system?).

6. Consider a pilot or demonstration project that will explore the "payment reform" and/or "service delivery reform".

7. Request that the Department of Defense increase reimbursement to civilian hospitals that provide services to active military personnel.

E. Health Insurance Reform

1. The impact of proposed rating rules to the individual and small group markets are an area of concern and should be watch carefully.

2. Insurance reforms (in and out of the Exchange) should apply to individuals and groups <50 prior to 2016, to target the employer segment that has the lowest coverage offer rate and to keep employers in the insured market.

3. A study should be conducted to identify the impact (actuarial, economic and social) of the state's mandates that are above and beyond the federally essential benefits and to determine if the state is responsible for funding these subsidies.

4. Connecticut should implement wellness discounts by applying to be a federally funded pilot state.

5. Require insurance transparency by establishing appropriate medical loss ratios and accurate definition of administrative costs.

6. Encourage a review of federal laws and regulations such as ERISA, which hinders state efforts to reform. Encourage the development of broad standards rather than prescriptive rules whenever possible. This will maximize state flexibility to implement reforms in a manner that is responsive to local and regional market conditions.

G. Improving Quality/Health System Performance/Cost Containment

1. While federal reform seeks to bend the cost curve associated with health care costs, the growth in these costs will be an ongoing challenge to the sustainability of these reforms. A critical next step toward controlling these costs will to develop a clearer understanding of the underlying factors that act in concert to produce higher health care costs. These factors include payment systems that often reward more care than more value, price inflation and inefficiencies along the payment and supply chain and price insensitivity among many consumers, technology driven inflation, role of social norms and values and other factors.

2. As critically needed interventions to control costs such as comparative effectiveness research, prevention programs, more coordinated care and other approaches are considered, careful analysis of the costs and benefits of specific interventions, rather than broad generalizations, will be critical to their success. Important elements of the national reform plans are the research and demonstration programs that will further test these approaches.

3. Our health care systems must begin to move away from the current fee for service payment system that values volume over quality. Alternative models in this regard include the development of accountable care organizations, some bundling of payments and pay for performance. Consider pilot or demonstration projects in these areas.

4. Explore proposed alternatives to malpractice tort reform. Possible consider multi-state agreements whereby physician review panels from neighboring states would review medical liability claims before referral to courts.

5. Support opportunities that expand programs for primary care physicians, nurses and nurse practitioners, medical office management, and health information technology specialists.

Deputy Commissioner Vogel, with the assistance of Board members, will revise the Guiding Principles based on the discussion at this meeting and agreed upon edits. The revised draft Guiding Principles and the draft interim report will be presented at the next meeting on January 29 for consideration and approval. Deputy Commissioner Vogel explained that the Interim Report will be the first report out in Connecticut addressing federal health care reform and it is her expectation that the Guiding Principles will not become outdated and the report will have a good shelf life. The Board members were invited to consider having a public hearing on this issue sometime in the next six months.

Other Business

No other business was raised.

Next meeting – Friday, January 29th, 2010 –from 9:00 – 11:00 am in LOB Room 1A

Future meetings (Legislative Office Building Room 1B):

Thursday, February 4, 2010, 9:00 – 11:00 AM
Tuesday, February 16, 2010, 1:00 – 3:00 PM
Thursday, March 4, 2010, 9:00 – 11:00 AM
Wednesday, March 17, 2010, 9:00 – 11:00 AM

The meeting was adjourned at 12:10 PM.