CT Health Care Reform Advisory Board

Minutes of December 3, 2009 Meeting

Members Present: Deputy Commissioner Cristine Vogel (Chair), Department of Public Health (DPH); Cathy Bartell, MHA; Mark Bertolini, Aetna; James Cox-Chapman, MD, ProHealth Physicians, MSO, Inc.; Christopher Dadlez, Saint Francis Hospital and Medical Center; Commissioner Robert Galvin, MD, DPH; Paul Lombardo, State Insurance Department (SID); Mark Schaefer, Department of Social Services (DSS); Rick Willard, Leadership Council of the National Federation of Independent Businesses; Tom Woodruff, Office of the State Comptroller.

Members Absent: Robert Dakers, Office of Policy and Management (OPM); Carole Noujaim; Lenny Winkler, RN.

Guest: Caroline Pearson, Avalere Health LLC

Review and Approval of Minutes

Deputy Commissioner Vogel called the meeting to order at 9:05 AM.

A motion was made to accept the minutes of the November 17, 2009 Advisory Board meeting. The motion was presented, seconded and passed unanimously by the Committee members.

Presentation: Overview of the Massachusetts Connector Experience

Caroline Pearson, of Avalere Health LLC in Washington, DC, made a presentation on the Massachusetts Universal Coverage Initiative. The presentation provided a description of the Massachusetts initiative and a discussion of lessons learned. Massachusetts aimed to achieve universal coverage through Medicaid expansions, individual and employer mandates and penalties and insurance market reforms. The focus was on coverage expansion with less attention to cost control. When comparing Massachusetts to other states, it is important to keep in mind that they already had some of the current proposed insurance market reforms in place in the form of an exchange market model in which benefit design and premium costs are negotiated; one of the lowest rates of uninsured in the country which has now been halved to 5.5 percent; a relatively high per capital income; a large state and federally funded uncompensated care pool program from which to redirect funds to help offset costs; and bipartisan cooperation. The presentation raised issues of cost control, premium affordability and subsidies, and meeting an increased demand for primary care. Massachusetts has successfully expanded coverage to nearly all residents. The remaining uninsured are illegal immigrants, younger and healthier

individuals under 40, and non-tax filers since implementation of the Connector is through the tax code. There is also mixed evidence as to whether expanded insurance coverage implies access. People in Massachusetts now generally have more access to care, although in the initial stages of the expansion there were long waits for primary care and access challenges for low income families in Medicaid Managed Care. Uncertainties about "crowding out" of private coverage had been unfounded since the uptake of employer-sponsored coverage actually increased and a small group and individual coverage plans market continues to thrive outside the exchange. One lesson learned is mandates and penalties work because people are generally compliant to mandates. However, cost control and sustainability remain an ongoing challenge. To address this, the Special Commission on the Health Care Payment System was created. In the Commission's first report, development of a global payment system was recommended. For more details on the presentation read **Mass Universal Coverage Initiative.pdf**

Following the presentation, Advisory Board members were invited to ask questions or provide comments:

- From 2006 to 2010, spending on health care in Massachusetts increased by $707 million. To what was this increase applied, where did the dollars come from, and what was the impact on providers? → New spending was due to premium subsidies and Medicaid expansions. The funding came from federal sources and increases in provider taxes (employer mandates). There was a decrease in bad debt, but an up tick in 2009 that may be at least in part attributable to the larger economic crisis.
- In Massachusetts, emergency room use was unacceptably high prior to implementation of health care reform and it is still high now. They are not seeing the downward trend they were anticipating.
- Canada achieved universal national health care insurance coverage by starting in one region. Citizens tended to like it and gave it high marks. This experience makes a case for experimenting on the state level.
- Is the entire premium for a plan $4,700? →Yes, it is the average premium for individual coverage and the employer pays a minimum of 33 percent of the premium. Looking across the U.S., this amount falls at the high end. Family coverage is at least double this amount. In Massachusetts, employers are only mandated to cover the employee, not the entire family. National health reform may require employers to cover the entire family.
- Access to insurance does not necessarily improve the health and well being of citizens. Efforts to support wellness and prevention must be built into the system.
- In Charter Oak, a key to keeping premiums low are lifetime and annual maximums. How did Massachusetts approach this in the Silver and Bronze plans? → The Massachusetts plans are not allowed to have these limits.
- With regard to access to care, how is reimbursement for primary care approached? → There is no systematic policy intervention to deal with that.
- What is the financial stability and loss ratios for the silver and bronze plans? → It is difficult to track medical loss ratios. In Massachusetts there are mostly regional non-profit plans that typically have lower ratios. There is low enrollment in these plans, so selection is an issue. However, there is no evidence that the plans are unsustainable. Large national health insurance plans have been absent from the

Massachusetts market due to insurance reform that occurred prior to the Universal Coverage Initiative.

- What are the differences between the uncompensated care pools in Massachusetts and Connecticut? → Connecticut does not have an uncompensated care pool, but does participate in the federal Disproportionate Share Hospital (DSH) program.
- Would Massachusetts say that the platform they are on is sustainable? → There is much approval and optimism about health care reform in Massachusetts, although they do acknowledge that issues of cost must be addressed.
- How is cost containment being addressed? → Massachusetts has established the Special Commission on the Health Care Payment System and they are looking at long term solutions, such as global budgeting, instead of short term fixes.
- Where does the Connector get its authority to change plan design? → The Massachusetts legislature designated a lot of responsibility for plan design and premiums for the Connector to an independent authority/board. The board works closely with the State to implement their decisions on the Connector and sometimes recommended changes are implemented through legislation.
- A health insurance exchange will be one of the first items states will be asked to implement. If there are too many plan choices, there is confusion. If there are too few, there is little interest. Group size is an issue on the federal level to pay attention to. Transparency tools would also need to be considered. In Connecticut, the average cost of a plan is $4,700 for an individual and $12,000 for a family. The State of Massachusetts is subsidizing premiums because it had about a $1 billion in its coffers. Connecticut has not addressed premium subsidies.
- Global budgeting is the next big issue after health insurance exchanges.

A suggestion was made to broaden the work of the Business Subcommittee to consider: health insurance exchanges, how to integrate small group and individual health insurance, an individual mandate, and risk adjustment.

Deputy Commissioner Vogel thanked Caroline Pearson for her presentation and remarked that this information will be helpful to stimulate the thinking of Advisory Board members as they consider their interim report and possible short term actions to implement in the next legislative session.

Update on Federal Health Care Reform Legislation

Paul Lombardo briefed the Advisory Board on the status of federal health care legislation and what has happened in the last two weeks, focusing on the different features and financing proposals between the House and Senate bill. Overall, the two bills are primarily similar in terms of broad topics, with the biggest difference in terms of financing. For more details read the **KFF Senate Vs House Major Health Care Refom Proposal .pdf** and **Kaiser Family Foundation CBO Report.pdf**. Until a single bill is developed the details of how federal health care reform will affect states will not be available. However, health insurance exchanges are a large feature of both bills and a good issue for the Advisory Board to focus on.

Subcommittees

Deputy Commissioner Vogel reviewed the freedom of information requirements for meetings. The same requirements apply to both the Advisory Board meetings and any subcommittee meetings. All meetings are required to be noticed in terms of date, time, location and agenda, to produce minutes and to be open to the public. Meeting minutes should be posted within seven business days of the meeting. No policy discussions or votes may be conducted via email.

For discussion at the next meeting, the Advisory Board was asked to consider the process for formulating the subcommittees. Specifically, whether the Advisory Board should vote on acceptance of proposed subcommittee members or leave that decision up to the subcommittee chairs.

Next Meeting – Thursday, December 17, 2009

Deputy Commissioner Vogel summarized the items considered for the next meeting:

- Presentation on the Small Group Market - Rick Willard and possible guest speaker
- Presentation on health information technology in Connecticut
- Activities of the Sustinet Board of Directors
- Discussion of subcommittee membership
- Federal legislative update

Advisory Board members are encouraged to submit any suggestions for presentation topics and speakers to Deputy Commissioner Vogel.

Meeting agendas, minutes, and handouts will be posted on the Office of Health Care Access website. Members of the public who are interested in getting meeting notices can sign up for e-alerts on the OHCA website at http://www.ct.gov/ohca.

The meeting was adjourned at 11:00 am.