

Testimony Before the Public Health Committee

Proposed S. B. No. 1 AN ACT INCREASING ACCESS TO AFFORDABLE, QUALITY HEALTH CARE.

H. B. No. 6838 (RAISED) AN ACT CONCERNING THE USE OF TELEMEDICINE TO PROMOTE EFFICIENCY IN THE DELIVERY OF HEALTH CARE SERVICES.

H. B. No. 6839 (RAISED) AN ACT CONCERNING HEALTH INFORMATION TECHNOLOGY.

H. B. No. 6976 (RAISED) AN ACT CONCERNING CHRONIC CARE MANAGEMENT.

Michael P. Starkowski
Acting Commissioner
January 31, 2007

Good morning, Senator Handley, Representative Sayers, and members of the Public Health Committee. My name is Michael Starkowski. I am the Acting Commissioner of the Connecticut Department of Social Services. Thank you for this opportunity to testify before your committee on several bills on the public hearing agenda.

Proposed S. B. No. 1 AN ACT INCREASING ACCESS TO AFFORDABLE, QUALITY HEALTH CARE.

First of all, I would like to applaud the Senate Majority Leadership and the members of this committee for recognizing the importance of access to healthcare in the discussion about the uninsured. Governor Rell has made it very clear that her priority is to promote universal access to health insurance coverage. Whatever solution we ultimately adopt in this session will take us much further down the road to making affordable health care available in Connecticut. But we all have to understand that a true system, where every child and adult carries health insurance, is probably a goal that lies beyond the power of any one state to achieve.

The details of Senate Bill No. 1 will continue to emerge over the next few weeks. Based on the general information available, this proposal is focused on an expansion of the public programs (Medicaid, HUSKY, and SAGA) as the path to reform. Included in that idea are certain assumptions about the willingness of the federal government to participate in such an endeavor, such as the expansion of the SAGA program under an 1115 waiver. Our experience at the Department has been that these waivers ultimately must address the issue of budget neutrality for the federal government. While the President has signaled to state governments that he is interested in helping them with coverage for the uninsured, achieving full budget neutrality could be near impossible.

On the issue of access, this proposal relies on the expansion of the public programs to achieve its goal. But the data on the uninsured clearly identifies that many of these individuals who have no coverage are working with incomes that will ultimately prove to be too high to be covered under Medicaid, for example, nineteen percent of our uninsured have incomes greater than three hundred percent of the federal poverty level.

The challenge that the Governor has posed to the insurance industry is to craft a benefit package that is affordable for your neighbors who may not want a public entitlement and cannot afford existing commercial health insurance premiums. It has to be basic coverage with copays, coinsurance and deductibles to make it affordable. And, as Governor Rell has acknowledged, the premiums need to be supported on a sliding scale basis. That is the essence of the Charter Oak Health Plan.

I have attached a copy of a presentation on the Charter Oak Health Plan for your review and I will not take up your time here today to elaborate on details. I look forward to working with you on a Connecticut solution to the problem of the uninsured. We can all be proud that our state already has done a great deal to keep the magnitude of this problem much smaller than it is in other states.

In recent discussions with the federal Center for Medicare and Medicaid Services (CMS), it was confirmed that President Bush's Affordable Choices Initiative provides a vehicle for states to receive federal financial assistance to help its uninsured. Governor Rell has written to Secretary Leavitt at the U.S. Department of Health and Human Services expressing Connecticut's interest in pursuing this federal support and requesting clarification and information on how Connecticut could take advantage of this opportunity.

It is critical that we all make a commitment to work together on the details of a solution which is affordable and sustainable for our state.

**H. B. No. 6838 (RAISED) AN ACT CONCERNING THE USE OF
TELEMEDICINE TO PROMOTE EFFICIENCY IN THE DELIVERY OF
HEALTH CARE SERVICES.**

In recent years, the practice of telemedicine has evolved from its inception as a delivery system in the frontier areas of the country where the nearest doctor could be literally hundreds of miles away to a system that enhances the efficiency and effectiveness of healthcare services without regards to the proximity of the patient to the healthcare provider. Healthcare systems, patients and advocates have accepted and in fact endorsed telemedicine as a viable response to the shortage of qualified and participating healthcare providers such as RNs and LPNs.

We at the Department have explored the concept of telemedicine as part of our strategy for the management of chronic illnesses like diabetes that are so costly in the Medicaid program. Last summer we submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) to implement a telemedicine project with the home health agencies in our state as part of that strategy. While that project ultimately was not funded, we continue to believe that telemedicine has an important role to play in the delivery of healthcare services to homebound patients and, in particular, can serve as a critical component of disease management systems.

I would happy to explore other options with the committee that address the role of telemedicine for our clients.

**H. B. No. 6839 (RAISED) AN ACT CONCERNING HEALTH INFORMATION
TECHNOLOGY.**

There is a great deal of interest across the country today in the development of an electronic medical record system and the promise that it holds for improved safety, quality, and efficiency in the delivery of health care.

Let me say that venturing into eHealth as a state is no small task, and that a system that is universally adopted for all aspects of health care delivery may be a few years off. I am

very pleased to tell you that we have made great strides towards the development of an eHealth record at the Department of Social Services. In response to the solicitation for Medicaid Transformation grants in the Deficit Reduction Act (DRA), we submitted three applications, each of which touched on some aspect of eHealth records. One was the telemedicine proposal for disease management that I described earlier. Another would have funded the development of an automated, online EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) record, which would be accessible by providers and parents in the HUSKY program.

While the telemedicine and on-line EPSDT record proposals were not selected for funding, we were awarded \$5 million for the development of an *E-Prescribing* system. Practitioners will be able to input and access patient medical history and adjudicate such issues as prior authorization, generic substitution, adverse drug interactions, and patient allergic reactions for all of the pharmacy programs administered by the department.

While our initial indoctrination into the eHealth arena involves e-prescribing, we will develop the building blocks for the emedical records of the future. To demonstrate her commitment to eHealth in Connecticut, Governor Rell has earmarked \$500,000 in the DSS budget to supplement the federal award.

We feel we have the opportunity to be a model for the country as we utilize technology to its capacity to enhance the quality and effectiveness of healthcare services by providing medical practitioners with the latest interactive tools and secure information systems to meet the needs of their patients.

H. B. No. 6976 (RAISED) AN ACT CONCERNING CHRONIC CARE MANAGEMENT.

Finally, I would like to comment on Raised Bill No. 6976. I am pleased to advise the committee that the Department is in final stages of the process of issuing a \$1.5 million Request for Proposals to select disease management entities to address chronic conditions such as juvenile obesity and diabetes and congestive heart failure and other cardiac conditions. In addition, Governor Rell has authorized an additional \$500,000 in the *Easy Breathing Program* to improve the treatment of asthma, which has proven so successful under the direction of the Department of Public Health.

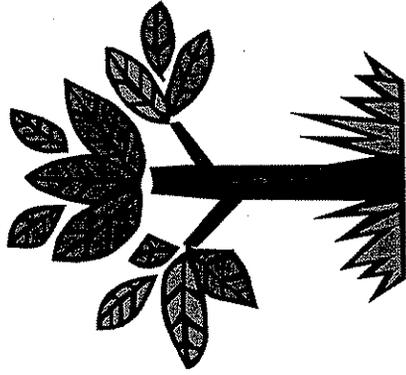
We know that it is morbidities and co-morbidities associated with chronic diseases that are the true cost-drivers in health care in America today. Programs that empower patients to take better care of themselves and to adhere to medical treatments that are evidence based will ultimately prove to be the best investment of our health care dollars.

While I appreciate the emphasis throughout the proposed bill on chronic care management, i.e. disease management, I am fearful that in establishing a new plan, a new advisory board and a host of new requirements and reports, we may be delaying the implementation of essential disease management services. That being said, I look

forward to working with you on the details of how we can develop an efficient and effective chronic disease management system.

That concludes my prepared remarks. Thank you for your time. Members of my Medicaid staff are here with me today and we would be happy to answer any questions that you might have.

THE CHARTER OAK HEALTH PLAN



Michael Starkowski
Commissioner
Department of Social Services
January 2007

“My goal is to make sure that every adult and child
in Connecticut has access to health insurance.”

-Governor M. Jodi Rell (December 27, 2006)

The Problem

- Connecticut has 340,000 residents who at some point during the 12 month period that was surveyed had no health insurance [OHCA data]
- Based on the December 2006 OHCA “Snapshot in time” Survey, 222,000 residents were without health insurance at the time the survey was done
- While Connecticut has large populations covered by public programs [HUSKY – 310,000, Medicaid FFS – 100,000, Medicare – 600,000, SAGA – 30,000] many of the uninsured are too old for HUSKY, too young for Medicare, too healthy, and too employed for Medicaid or SAGA.

Changes in the Health Insurance Environment

- At the same time, many employers are finding it harder to provide affordable coverage to their workers and dependents.
- Younger workers, especially self-employed or those employed by small employers, often choose to decline coverage due to high cost, even if it is available.
- Many students seeking higher education and those starting their first jobs are highly likely to be uninsured.

Goal

- While there is significant discussion around “universal health care” there is no standard, common definition for universal health care
- Governor Rell’s goal is to provide universal access to affordable health insurance.

Challenge

- Can health insurance companies provide affordable, creditable coverage to the uninsured?

Key Characteristics

- Coverage through a private model.
- No pre-existing condition exclusion.
- State investment in outreach and marketing.
- State participation in sliding scale premium assistance
- No individual or employer mandate.
- Participation is strictly voluntary.

Proposed Benefit Design

- Annual Deductible - \$1,000
- Coinsurance— 20% after the deductible is met up to \$1,000.
- Lifetime Benefit - \$1 million
- Members must have been without insurance for 6 months in order to purchase the product.

Proposed Benefit Design (cont'd)

- Pharmacy
 - Multi Tiered Co-pays
 - Generic Utilization
 - Formulary Adherence
 - Availability of Mail Order
- Office visit Co-pays
- Visit limits on behavioral health
- Lab, X-ray, Surgery, Hospitalization, Maternity
 - 20% co-insurance after deductible

Proposed Benefit Design (cont'd)

- Emergency Room
 - \$100-150 co-pay for non-emergency visits
- Hospital
 - No fee for emergencies
- Outpatient
 - No fee if admitted to the hospital
 - 20% co-insurance for urgent visits
 - co-pay for prenatal and post-partum visits
- No coverage for dental, vision, hospice
- Limited coverage for skilled nursing

Next Steps

- Further refine the benefit design.
- Issue an Invitation to Participate (ITP) to the health insurance industry challenging them to meet the proposed benefit package as an affordable community rated product (estimated to be \$250 per month or less)
- Allow respondents to identify the appropriate monthly premium, if it actuarially exceeds the est. \$250 per month
- Allow respondents to propose “minor modifications” to proposed benefits in order to meet the \$250 or less per month.
- Based on sliding income scale, state will subsidize premiums with higher income individuals responsible for full premiums