

# HealthFirst Connecticut Authority

Co-Chairs  
Margaret Flinter  
Tom Swan



## Cost, Cost Containment and Finance Workgroup

### Meeting Summary

January 22<sup>nd</sup>, 2008

9:00 AM, Room 1D of the LOB

The following members were present: Tom Swan, Margaret Flinter, Jill Zorn, Eric George, Victoria Veltri, Alyssa Rose, John Harrity, Connie Razza, Alexis Kozmon, Fernando Betancourt, Yvette Francis, James Stirling, Robert Tessier, Bob Rinker, Sue Peters, Al Ayers, Henry Jacobs, Tanya Court, Michael Hudson, Robert Madore, Beverley Brakeman, Lud Spinelli, Stephen Frayne, Andrew Gold, Karl Ideman, Paul Lombardo, Joseph Pavano, Paul Filson, Mickey Herbert, Rob Caione, Adele Gordon

Also present were: Martha Judd representing David Benfer, Peter Toru representing Sal Luciano

Tom Swan welcomed everyone and asked that everyone introduce themselves.

Margaret Flinter welcomed everyone and explained the charge of the HealthFirst Authority:

#### Charge:

- To evaluate alternatives for providing quality, affordable and sustainable health care for all residents of Connecticut- including a single payer system and employer sponsored insurance.
- Recommend ways to contain cost and improve health care quality, including information technology, disease management, and other methods to improve care for people with chronic disease.
- Develop ways to encourage and require providing health care coverage to certain groups for participation in insurance pools.
- Recommend ways to finance the insurance program and maximize federal funding as well as ways to pay the state share of the costs.

Margaret Flinter reminded the workgroup of the institute of medicine's principles:

Coverage should be universal, continuous, affordable to individuals and families, affordable and sustainable for the society, and enhance health and well being for society. Care should be efficient, effective, safe, timely, patient centered and equitable.

Tom Swan explained to the members that the Cost, Cost Containment and Finance Workgroup, as well as the Quality, Access and Safety Workgroup had been created to broaden the discussion over how to

improve the health care system in Connecticut. Compared to California, we do not have a county government, we have a smaller number and percentage of uninsured, we have a more employers that provide healthcare, and we are considered the insurance capitol of the United States. These facts will guide our unique solutions to our healthcare problems. The United States spends more money on healthcare than any other country in the industrialized world and yet we have huge problems with our healthcare system. Our challenge will be to identify the healthcare system we need, and to address how to finance and structure that in a way that makes it equitable and guarantees access to healthcare.

Eric George told the Workgroup that a lot of the discussion will relate to the health status of Connecticut. 75% of health care costs are attributable to our lifestyles. Connecticut has under funded Medicaid. This has resulted in a \$300 million cost shift to the private sector and employers. The state has paid 70 cents on the dollar for hospital costs. That has raised the commercial markets hospital costs 15%. These are areas we will have to address. Preventable errors must also be addressed. Electronic medical records (EMR's) may impact cost in a very positive way in addressing preventable errors. We must also discuss the number of mandates we have in Connecticut and the impact that has on premiums.

Victoria Veltri asked what the goal of each of the three areas is: Cost, Cost Containment, and Finance. Underinsurance must be looked at. This can translate into high health care costs. Victoria conveyed her interpretation of cost to be the costs associated with the current system. Cost Containment includes the ways to contain costs and Finance includes the funding source of the plan that is offered to the Legislature by the Workgroups and Authorities.

Tom Swan answered Victoria and said "Cost," includes what the new system would cost and how to finance it. He also offered a preliminary timeline by which a recommendation must be created by the Workgroup.

Henry Jacobs reported briefly to the Workgroup the progress and setbacks surrounding the changes to the healthcare system in Massachusetts.

Fernando Betancourt urged the Workgroup to think about the goals they can agree on and the process by which those goals may be reached. Second, we must look at how we can make that system efficient and cost effective.

Michael Hudson asked the Workgroup to use studies that have already been done on the nature of the uninsured in Connecticut so that there is a good fact base. He also asked how both of the Workgroups could work together.

Tom Swan responded that he was open to suggestions but agreed that it would be important for the Workgroups to work in unison.

Paul Filson asked if the Workgroup should consider what changes may be made by the Federal Government.

Tom Swan suggested that the Workgroup pay attention to what might be happening in Washington but not rely on any changes that may or may not occur.

Bob Madore asked for an explanation of the scope of the charge to the Workgroup.

Tom Swan responded that the Workgroup is looking at systems change. Items pertaining to delivery will be discussed by the Quality, Access and Safety Workgroup. The Cost, Cost Containment and Finance Workgroup will focus on how the flow of funding will change, how much items will cost, and if there is a transitional cost that the state or consumers may need to pay for healthcare.

Margaret Flinter added to Tom Swan's comments that the scope should be broad instead of narrow. Ultimately the Workgroup must make a suggestion as to how the healthcare changes will be paid for. The Primary Care Access Authority was given the charge of developing universal access to primary and preventative care in Connecticut. This will require the inventorying of the infrastructure of primary care.

Mickey Herbert cautioned the Workgroup not to look for a "big bang," solution that was attempted in the 1990's. However, there are many incremental reforms that are probably necessary. He also cautioned against putting money into government run programs to solve the problems without structural reform, prices will be driven up and healthcare will be less affordable.

Tanya Court added that our goal should be to improve health outcomes and reduce racial disparities.

Beverly Brakeman reported that one of the reasons healthcare prices were high was because a significant number of the citizens of Connecticut are uninsured. She also disagreed with Mickey Herbert and suggested that there needs to be change made to the healthcare system sooner rather than later and some of those changes may need to be significant. Beverly also asked for clarification over two comments that were made. During the meeting, one member of the workgroup reported "75% of our healthcare costs are due to unhealthy lifestyles," and another report claims that "75% of our healthcare costs are related to chronic care," are these two statements related to the same findings?

Mickey Herbert said that the findings they had made were based on adding up the claims costs of preventable diseases over a long period of time.

Margaret Flinter reported that a focus of the Workgroup would be dealing with preventable diseases.

Tom Swan expressed interest in the utilization of emergency rooms.

Henry Jacobs reported that the problem is with patients who have Medicaid who are unable to get doctors to see them. The doctors refuse to accept the low reimbursement rates that Medicaid offers. As a result, patients end up in the emergency room. We have a shrinking and inadequate population of primary care providers in the State. The rate at which that population is shrinking is alarming. The population of experienced nurse providers is also shrinking. We must ask what you do with someone who has a chronic disease and need a primary care provider to look after them, if there is no one to see them.

John Rathgeber reported that health care costs have trended at three times the Consumer Price Index since the 60's. Part of that cost is driven by the risk profile changing over time. Cost follows risk and we must improve the risk profile of our populations.

Mark Sudock summarized findings given to Governor Rell's task force. There are 1.5 million visits a year to a hospital emergency department which is about 4,100 people a day. Of those visits, 600,000 are for things that could probably be treated elsewhere. When the task force adjusted the utilization for insurance status, we found that people without insurance do not use the emergency room more than people who do have insurance through their employer. They use it at a slightly higher rate, but not drastically higher. It is the general assistance population and the Medicaid population which do not have access to private physicians. They use an emergency department at three to four times more than the insured. Physicians do not care for that population because the payments are 50% to 60% of what is paid by Medicare.

Martha Judd added that specialty care is a problem. For Medicaid, SAGA and the uninsured, the only time they can get specialty care is to go to hospital clinics. Many time people wait for their illnesses to reach an acute stage and then they end up in the emergency room. On any given day the ER struggles with mental health access and capacity. Patients are often held longer than necessary because of a lack of referral sites. Overcrowding in the ER's is sometimes caused because inpatients can't be discharged to appropriate sites.

Ludwig Spinelli suggested the Workgroup use the Universal Healthcare Foundation reports. He agreed with Mickey Herbert that the State would not fund drastic changes to the healthcare system.

Sheldon Toubman told the Workgroup that we have a bad three tier system of healthcare. It is important to represent the needs of the extremely low income patients. We need to look at the total administrative costs and profits of subcontractors in the system right now. This may be a factor in the inefficiencies in the healthcare system. The primary care provider is responsible for coordinating care, deciding on referrals, and record keeping that allows the government to follow the system of care. . In a situation in Oklahoma similar to the situation in Connecticut now, the State moved to a system of primary care case management. In the first year they saved about \$5 million dollars. They continue to save money despite the fact that they pay 100% of Medicare to their doctors.

Victoria Veltri asked for a closer look at the types of things the health care dollar is spent on such as reimbursement for providers, administrative costs, subcontractors etc. We need an objective look at each health care dollar and how it is spent. Until we have that information we can't move forward. She recommended that subcommittees be balanced in terms of advocates, medical providers, and insurance carriers, and an actuary be available as a reference.

Adele Gordon asked how oral health would be brought into the discussion.

Tom Swan answered that issue would be addressed by the Quality, Access and Safety Workgroup.

Fernando Betancourt offered his opinion to the Workgroup that we should look at ourselves as an agent of change, and the Workgroup should not limit their recommendations because they do not think the political will to make changes exists.

Tom Swan thanked everyone for attending the Workgroup meeting.  
The meeting was adjourned at 11:00 PM.