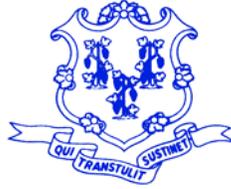


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Cost, Cost Containment and Finance Workgroup July 29th, 2008 Room 1E of the LOB Meeting Summary

Those present were: Margaret Flinter, Tom Swan, Ellen Andrews, David Benfer, Linda Lorenzi, Lou Brady, Paul Filson, Stephen Frayne, Andrew Gold, Paul Grady, John Harranty, Mickey Herbert, Sanford Herman, Yvette Highsmith-Francis, Sharon Langer, Paul Lombardo, Sal Luciano, John O'Connell, Eric George, Bob Rinker, Sheldon Toubman, Rich Sivel, John Farrell and Neil Ferstand.

Margaret Flinter gave updates of the work of the HealthFirst Authority.

Tom Swan informed the Workgroup that a handout with the state's expenditures on healthcare had been distributed. The public sector makes up a large portion of expenditures.

Bob Rinker asked if the Office of Fiscal Analysis could check the state employee number.

Tom Swan introduced Jeff Lemieux for the purposes of a presentation. Jeff Lemieux is a senior vice president within the policy department of America's Health Insurance Plans (AHIP).

Jeff Lemieux offered a presentation on health insurers' perspective on health reform. Jeff Lemieux informed the Workgroup that the number of uninsured in Connecticut is very low relative to other states (approximately 9%) and the percentage of employers offering coverage is very high. Connecticut has a higher than average premiums in the individual market but near average.

During the healthcare debate of the 1990's, one of the positive outcomes was to put some pressure on businesses to experiment with managed care and to encourage health plans to experiment and innovate in providing health insurance benefits and in working with providers. One figure that is of some concern to AHIP is the growing number of uninsured. Between 2004 and 2006, the numbers of uninsured and children with no insurance has grown by several million, and this is during a time of moderate economic growth in the country. The number of uninsured has grown as fast or faster among high income groups as compared to lower income groups. Part of the reason for the drive towards universal coverage the extra amount in the average health insurance premium that's due to uncompensated care from the uninsured has grown and this is an enormous problem. There is also concern about the decline in payment rates in public sector programs.

In some places hospitals become so large that they corner the market and it becomes difficult to negotiate favorable rates. Costs are increasing for many reasons. The hospitals claim that the rates that

people were paying were not high enough to begin with. There has also been an increase in the use of MRI's and this is an expensive procedure.

There have been complaints that administrative costs of health insurance plans have been too high. All types of health insurance have been studied and although there has been some fluctuation, the rate of administrative costs has been at approximately 12% over the past few decades.

Medicare and Medicaid administration rates have also been studied and their rates have risen over the last ten years as they have tried to include more care management and information technology.

Jeff Lemieux described where AHIP is planning to focus its energies in the future. AHIP continues to raise awareness of the S-CHIP funding situation, encourages federal proposals ensuring that all states get Medicaid at least up to 100% of the Federal Poverty Level (FPL), federal tax credits to help parents cover their children, and finally a grant to states to help individual states improve their healthcare systems and to help states improve their high-risk pools. Improving small group coverage, modeling schemes for subsidies, and portability of coverage is all issues that AHIP is discussing.

Bob Rinker asked if there is anything that the plans are doing to drive a national system that would provide evidence based medicine.

Jeff Lemieux responded that AHIP is lobbying for a national comparative effectiveness system, and AHIP is willing to help pay for such a system. Jeff suggested that there should be a federal mandate that determines what type of system is used.

Margaret Flinter asked about the role of insurers in a system that includes electronic health records. Why isn't it reasonable to bill the charge to a major payer.

Jeff Lemieux agreed that personal health records should be transferable between plans. A protocol for electronic records has not been created.

Margaret Flinter asked if it would be possible to pay through the reimbursement system.

Jeff Lemieux suggested that AHIP would probably be open to discussion of that issue.

Eric George asked if national standards were necessary for an electronic health records (HER) system. He asked how far away an EHR system was.

Jeff Lemieux responded that an EHR system was probably far away. There are some companies that are currently trying to push their plan for EHR guidelines forward.

Mickey Herbert commented that there is an administrative simplification committee that is making real progress towards interoperability. There may be real progress there but health plans are not in a position to pay for such a system.

Paul Filson asked about providing funding for high risk pools and what that meant.

Jeff Lemieux responded that AHIP felt that states should move forward in a way that is most effective in that particular state.

Sanford Herman asked if the Federal solution could include a standardized plan that would be a safe harbor where a carrier could have a set of plans that could be sold in all fifty states.

Jeff Lemieux responded that there could be a national plan that one could buy into.

Sanford Herman discussed the mandate issue and the need to comply with fifty sets of state mandates. A national set of mandates would make it easier to run a healthcare plan.

Jeff Lemieux informed the Workgroup that there had been some proposals that would allow for an insurance policy that is regulated by any state. AHIP has opposed those proposals because do not include a regulator if there was a problem.

Tom Swan discussed the original proposal that he had received. That proposal included a proposal that allowed small businesses to buy insurance from other states. Administrative fees have increased and it is probably true that the increases were due to privatization and utilization of plans. Tom Swan informed the Workgroup that the next meeting would focus heavily on the issues of mandates and malpractice.

Jeff Lemieux agreed that administrative costs included self-funded plans and state regulated plans. Administrative costs of covering a small group or individual are higher just because of the communication and marketing costs. The rates are also higher because the premiums are lower. The administrative costs for the state regulated market tend to run about twice as high as the fully insured market. The market as a whole is on par with Medicare.

Tom Swan asked about the “campaign for an American solution,” and whether that was a campaign designed to block reform.

Jeff Lemieux replied that the campaign was not designed to block reform. It is a campaign aimed at building momentum for reform.

Tom Swan asked about investors from Wellpoint who claim they will not give up profitability for numbers of members.

Mickey Herbert replied that you cannot accuse health plans of earning excessive profits and then criticize them when they do not make profits. The president of Wellpoint was surely suggesting that it is the duty to earn a return on shareholders investments.

Neil Ferstand asked if AHIP has been concerned with the state contract which was proposed by the NAIC regarding the creation of the semi-autonomous independent regulatory agency in St. Lewis that regulates new offerings on healthcare plans by insurance companies.

Jeff Lemieux responded that AHIP would be happy to cooperate with such a program although they have not endorsed.

David Benfer asked Mickey Herbert about profitability which he had said was 2% and asked Mickey how that relates to the medical loss ratio and administrative costs.

Mickey Herbert responded that his medical loss ration is around 86%. Of the remaining 14%, 2% of that is profit and the value added services like disease management. Processing claims and paying taxes is also part of the remaining 14%. Brokerage costs are about 4% of the total dollar.

Tom Swan introduced Stephen Frayne for the purposes of a presentation on hospital financing, uncompensated care, and dish payments.

Stephen Frayne reported that the key findings of the Connecticut Hospital Association are 1.) Population is growing, 2.) Demand for services is up, 3.) Expenses are tightly controlled, 4.) Funding from patients is inadequate to cover expenses, 5.) Non-patient dollars routinely are diverted to cover current expenses, 6.) There is inadequate government funding to cover the cost of care delivered in Medicaid and Medicare programs, 7.) Investment in technology to improve quality and care delivery is delayed and dampened, 8.) Health insurance must cover the cost of care being provided and contribute to subsidizing the losses incurred in Medicare and Medicaid.

Over the past decade (1997 through 2006), Connecticut's population has increased 5% and more people are covered by Medicaid and commercial insurance. The percentage of those on Medicare and Medicaid has remained very similar although the number of those on Medicare and Medicaid has increased. During the same period the demand for inpatient services at hospitals has dramatically increased. Hospital admissions have increased by 17% during the past decade. While more patient stays are shorter, more newborns require intensive care services.

Hospitals have seen substantial increases in outpatient services. Today, outpatient services exceed inpatient by more than 10 to 1. Over the past decade there has been a 37% increase in the number of individuals that are showing up at the emergency department (ED). 85% of that increase in the use of the emergency department is due to increased frequency of use, and only 15% is due to population increase. The increase in use is due mainly to the fact that those who need care have no other place to go. Ambulatory surgery and rehabilitation services have also seen large increases in the last decade.

Abysmally low Medicaid physician rates fail to produce adequate access to physician offices. The result is overuse of the Hospital ED.

- Residents enrolled in Medicaid used the ED three times more often than the privately insured.
- Residents enrolled in SAGA used the ED six times more than the privately insured.
- For non-urgent care, Medicaid enrollees had nearly five times more ED visits than the privately insured.
- For non-urgent care, SAGA enrollees had over six times more ED visits than the privately insured.

If you were to look at overall expenses, 76% of hospital expenses are put into the people that come into the hospital. Expenses have grown at approximately 6.3% a year. Of that 6.3%, expenses are controlled at 4% and volume of input contributes 2.3%. Malpractice has gone up 100 million dollars in the last decade. The number of employees has increased because the population of the state has increased. Therefore, there is an increased amount of hospital spending that goes towards employees and employee benefits. After about \$70 Billion dollars in spending per year, there is about \$90 million dollars in profit which is relatively low. Six hospitals have actually closed in Connecticut despite growing demand for care.

Despite holding expense growth to a modest level, hospitals have been unable to cover the cost of patient care from patients. Losses are growing at twice the rate of expenses. Over the last decade, cumulative losses on patient care services top \$2.5 billion.

The largest drag on hospital financial health is Medicaid underfunding. Losses caring for Medicaid is nearly three times the loss caring for the uninsured, and two and a half times the loss caring for Medicare. Hospitals annually have virtually no funds to use for maintaining, replenishing, upgrading, or expanding services. Communities are short changed as funds are diverted from investment in facilities, technology, and improvements in patient care – to just make ends meet.

Medicare rates imply that hospital rates should increase 3.6% per year. Costs are going up more than that and Medicare is unwilling to recognize those costs. Medicare also has traditionally taken a long time to increase reimbursement. And Connecticut has also lagged in terms of hospital rate increases.

Ellen Andrews clarified that hospitals may charge those who receive service if they make more than 250% of the federal poverty limit (FPL).

Stephen Frayne responded that as a standard practice in the state, even though the law requires 250% or lower, many hospitals offer a sliding scale above that level.

Ellen Andrews expressed her relief and surprise that the uninsured are not the largest drain on the hospitals. It is important to know that people are stepping up and paying what they can for their hospital bills. It is interesting that Medicare patients are doing a good job of determining if they need to be administered to an emergency room or not. The number of physicians available to Medicare patients is far larger than it is to the uninsured. That seems to correlate strongly with access to care.

Eric Geroge asked how effective hospitals are at obtaining financing based on the 1.18 operating margin and some finance experts believe that hospitals should be able to achieve an operating margin that approaches 4.

Stephen Frayne responded that if you are a hospital and need financing you must get the money through banks and bonds that are privately secured.

David Benfer informed the Workgroup that even with the requirement of CHEFA to have insured debt, hospitals are enduring the credit crisis the way other industries are.

Mickey Herbert commented that the presentation points out that there is a hidden tax on business. Health plans have the same problem with cost shifting as the physician community. Medicare and Medicaid do not pay their fair share.

Margaret Flinter agreed that Medicare and Medicaid under-funds hospitals.

Sanford Herman asked whether similar situations exist across the country. Also, how do hospitals in southern Florida, where there is a huge Medicare population, survive despite Medicare under-payment.

Stephen Frayne responded that Connecticut is different in several ways. All hospitals in Connecticut are community non-profit except for one. We do not have a municipal hospital system.

Bob Rinker asked about potential conflicting information provided by the insurance agencies and hospital association regarding a lack of funding that hospitals have to invest in new technologies.

Stephen Frayne responded that he did not feel that there was conflicting information and made the point that the hospitals lack of funding makes it difficult to invest in new technology.

Bob Rinker asked if consolidation gave economies of scale.

Stephen Frayne responded that it did.

Bob Rinker commented that every time he has a child that is injured the doctor suggests going to the emergency room, even in cases where the child does not seem to need to go to the ER.

Neil Ferstand asked how information in the presentation was aggregated.

Stephen Frayne responded that every year every hospital is required to provide to the Office of Health Care Access (OHCA) financial statements, detail of all transactions between the hospital and any of its affiliates, and Medicare and Medicaid cost reports.

Tom Swan announced that a discussion of mandates will be discussed at the next meeting. Malpractice issues will also be addressed. Public hearings are also being scheduled across the state to allow the public to raise concerns and comments regarding healthcare in Connecticut.