2013 CT Health Intern Academy

Audience questions for health policy trends panelists

1. **How could you standardize “pay for performance” [as a payment structure for CT’s health system]?**

   From Deb Polun (CHCACT): “Pay for performance” is a model that is being tested, but as of yet, it is not really ready for full implementation across the health care system. Getting consumers to be more engaged in their own health care will be critical to the success of “pay for performance” efforts.

   From Vicki Veltri (CT Health Care Advocate): The discussion of payment reform models is at the heart of the state's innovation model design grant process. There is a consensus building around payment reform, but pay for performance is really a description of one of many types of models we are exploring to ensure that we are paying for value and good outcomes. Standardization requires aligning all interested stakeholders around a similar model. Alignment is the first step. We hope to achieve alignment in the next month or so around a model that stresses payment for value.

2. **The states have historically had jurisdiction over insurance. What will be the impact of ceding much of this control to the federal government?**

   From Mickey Herbert (consultant, Harvard Pilgrim): Bigger, more centralized government control over our lives… for better or worse.

   From Deb Polun: Connecticut will retain a lot of its control over insurance because we have a state-based Exchange.

   From Vicki Veltri: The states are still the primary regulators of insurance. As a matter of fact, with the rollout of Access Health CT, the state will retain control over the insurance market. Many CT residents are enrolled in plans that have never been regulated by the state. If you work for a large employer or a municipality, you're probably enrolled in a self-funded plan. These plans are regulated by the federal government, and the ACA did not change that.

3. **(2 on this theme) How are insurers going to financially handle those with pre-existing conditions coming into their plans? The penalty in 2014 is low, so many health people may not sign up.**

   From Vicki Veltri: The penalty in 2014 is low, so many health people may not sign up. Insurers will have to account for this in their rate filings. However, there are protections built into the ACA to protect insurers from absorbing increased risk. There are risk adjustments that will compensate plans that absorb higher risk. There's also re insurance that prevents insurers from

absorbing the costs of claims above a certain threshold. Finally, the risk corridors program also works to contain costs. The three Rs should help to avoid excess rate increases. The penalty is low in the first year, but with the federal financial help that is offered to people with incomes between 138%-400% FPL, we hope people will be encouraged to enroll. We also will be engaging in an intensive campaign to persuade people of the importance of having healthcare coverage. The board also has to be aggressive in ensuring that rates are the lowest they can be to make plans affordable for people.

From Mickey Herbert: This, to me, is the biggest unanswered question regarding the success or failure of the Affordable Care Act. Unquestionably, those with high health care needs, including especially those who have not been able to qualify for health insurance in the past are going to rush to sign up on January 1. For the ACA to work, we need the young and healthy to sign up, too, and they simply may not, at least not initially.
Here's what Justice Alito said in the court discussions leading up to the Supreme Court case last summer which upheld the Affordable Care Act*:

> *Mr. Alito pointed out that young, healthy adults today spend an average of $854 a year on health care. ObamaCare would require them to buy insurance policies expected to cost roughly $5,800. The law, then, isn't just asking them to pay for "the services that they are going to consume," he continued. "The mandate is forcing these people to provide a huge subsidy to the insurance companies . . . to subsidize services that will be received by somebody else."*

*From an article written by Holman W. Jenkins, Jr. and published on June 18 in the Wall Street Journal

4. **What are the projections for the HIX [CT health insurance exchange]? Will it be able to operate if enrollments are low or if it becomes essentially a high risk pool?**

From Mickey Herbert: Connecticut is a relatively small state. Our public HIX will be in trouble if we cannot enroll a significant proportion our state's uninsured, especially since it is unlikely that many employers are going to abandon employer-sponsored health insurance at the outset in the first few years of the public exchange. This makes the next couple of years highly critical to the ultimate success and viability of Access Health CT.

From Vicki Veltri: The funding for the HIX is stable. We do not project low enrollment because of the federal financial help available. It is our job to make sure that people who are healthy understand the importance of coverage. The carriers also have an interest in ensuring they enroll healthy people, so we think that our intensive outreach efforts will prevent low enrollment. The penalty also goes up in subsequent years -- that will also entice people to enroll.

5. **Will physicians want to provide the same level of care under a public health system as under the current system? Will quality of care slip if profits drop? Will people be assigned to doctors?**

   From Deb Polun: The federally qualified health centers (FQHCs) provide a good model to examine a system under which all people are treated, regardless of payer source. Physicians and other health care providers receive some benefits from working at FQHCs, including malpractice coverage and assistance with medical school loans, as well as the knowledge that they are treating those who are generally underserved.
   As for quality of care, FQHCs report quality indicators every year, which are posted online, so that the public has access to see, for example, how many children at that FQHC have received appropriate vaccinations and how many women have received appropriate Pap screenings. Quality reporting is expanding across the health care field, and having to report on quality incents providers to improve. Emerging payment models will also enhance the focus on quality of care provided.

   From Vicki Veltri: Yes. Providers get into the healthcare arena because they want to help people. Whether we have a public or private system, they want to do the right thing. Quality should not drop if profits drop. If we design our health system well, profits can sustain providers at the same time that quality goes up. People are not assigned to doctors. Under plans on AccessHealthCT, you pick your doctors. There will be a variety of plans offered. Some will have out of network services available, so you can see a provider who is not on your plan's list of participating providers.

   From Mickey Herbert: Too soon to tell, but it certainly bears watching. First telltale sign will be when it is revealed how many physicians even agree to participate initially in the health plans' public exchange panel of physicians. If we have very "narrow" networks with many docs and hospitals sitting on the sidelines, this will not bode well for the long-term success of the HIX.

6. **Do you know of any countries that provide coverage for all? Has the US examined these and/or adopted any of their practices?**

   From Mickey Herbert: Most developed countries provide coverage for a higher percent of their population than we do in the United States, even though we spend far more per capita on health care than any other country in the world. However, their cultures are different than ours, and it is no easy task to attempt to impose an alien culture on the United States. Case in point: Canada has a higher percent of its residents covered than we do here, but Canadians are far more willing to accept longer waiting periods to access care.

Interestingly, virtually every developed country is now faced with rapidly increasing health costs with little immediate prospect for bringing those costs under control. Many European countries are encouraging and relying on more privatization of health care to provide quality health care to their residents.

From Vicki Veltri: Many countries provide coverage for all as a right of residency or citizenship. Think of Canada and most of Europe. The US is looking more toward some of these models and the focus on primary care.

7. **How does the future look for insurers paying for care of special needs children? Currently a lot is not covered.**

   From Vicki Veltri: Right now, care for children with special needs is often not covered. As a result many children go uncovered and/or have to rely on programs offered by the state to fill the gap. The state cannot add any benefits to its insurance coverage for at least two years without the state incurring costs for the payment of additional services for those who would qualify for federal help. However, many benefits are offered, and if a family thinks something might be covered, please call OHA [the Office of Healthcare Advocate} for help. Our state's efforts at reforming our system must address the very significant under insurance problem for children with special needs. We have to figure out the best way to deliver care that works for families.

   From Mickey Herbert: We need to be careful not to ask too much of health insurers, lest we make health care unaffordable to all. Health insurers in Connecticut currently provide coverage that is more comprehensive than just about any state in America, and that coverage will become even more comprehensive on January 1. Health insurers cannot be expected, for instance, to pick up special needs <u>educational</u> expenses that are more properly the responsibility of our state's educational system.

8. Specifically to Mr. Herbert – You mentioned that regulating insurance companies' administrative costs is like regulating Apple's marketing costs – it won't be a problem as long as the percentage isn't pushed too low. Do you think that regulators and lawmakers in the future will have an incentive to keep that percentage sufficiently high?

   From Mickey Herbert: My main point was a broad one: that we have always had a marketplace approach to health delivery in the United Sates, and markets work best when we let price, service and quality be the overall determinants in whether a company (in this case, a health plan) succeeds or fails in that market place.

   Medical loss ratio legislation violates that precept by regulating a health plan's administrative costs, irrespective of how its product is priced, or its

level of service, or its overall quality. You don't see that in virtually any other facet of our country's market-based economy. Apple does not have to account for what it spends on marketing its i-products, or, for that matter, what it spends to produce those products.

To answer the excellent question posed: Yes, I worry about regulators and lawmakers setting the bar even higher, and requiring health plans to spend less and less on administrative costs-even forcing those plans to cut into key value-added services like utilization review, disease and demand management, and fraud and abuse detection. Even worse, it could eventually force health plans to exit the market, leaving fewer and fewer competitors. Our market-based system clearly benefits from many viable competitors, not a few that might be able to exert oligarchic power over the market.