Business Plan Work Group
Final Report and Recommendations
to
Governor Dannell P. Malloy
and
Connecticut State Legislature

Submitted
to the
Health Care Cabinet
October 9, 2012

Business Plan Workgroup Membership

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Business Plan Work Group Charge

The Business Plan Work Group was created by Public Act No. 11-58 as part of the SustiNet Health Care Cabinet. The legislation identified the purpose of the Business Plan Work Group as follows:

(5) (A) Develop a business plan to be provided to the Governor and the Office of Health Reform and Innovation that takes into account feasibility and risk assessments conducted pursuant to subsection (h) of section 13 of this act and evaluates private or public mechanisms that will provide adequate health insurance products commencing on January 1, 2014, including, but not limited to, for-profit and nonprofit organizations, insurance cooperatives and self-insurance, and (B) submit appropriate implementation recommendations for the Governor's consideration;

Building upon the legislative mandate establishing the Business Plan Workgroup (BPWG), the group interpreted the following charge which was agreed to by all members and approved by the Health Care Cabinet.

- Propose one or more business models that could effectively offer quality health coverage affordable to small businesses and individuals.
- Compile and analyze market, feasibility and risk assessment data in order to identify gaps in coverage, quality and affordability.
- Develop multiple scenarios for addressing such gaps including public, nonprofit and private approaches.
- Make recommendations for alternative approaches that would help secure universal access to quality and affordable health care.

Introduction/Overview

The Business Plan Work Group (BPWG) group approached its charge by keeping in mind the Health Care Cabinet's guiding principles (see Appendix A), specifically that the group's recommendations:

- contribute to the improved physical, mental, and oral health of all Connecticut residents;
- ensure equity in health care delivery and access, mindful of the goal of reducing disparities; and

- leverage existing knowledge, expertise and initiatives in both the public and private sector.

The work group studied health reforms already underway in Connecticut including the establishment of the Health Insurance Exchange, and innovations in the State Employees' Health Plan and Medicaid program. The group reviewed local, regional and national innovative models of coverage and care delivery, met with experts and utilized the expertise of its members. The BPWG sought to identify and understand which Connecticut residents would be most affected by gaps in access to affordable high quality insurance coverage and health care services and made our recommendations for addressing these gaps with special attention to uninsured and underserved populations.

A complete list of resources, presenters and experts consulted appears in Appendix B. Copies of all materials reviewed and presentations made to the BPWG appear on the Office of Health Reform and Innovation (OHRI) website, www.healthreform.ct.gov.

Findings

The BPWG concluded that a number of interrelated factors characterize the current state of our health care system and that these factors greatly contribute to unequal access to care, the high cost of care and difficulties in finding and enrolling in high quality and affordable health insurance. Health delivery system fragmentation, misaligned payment mechanisms for providers of care and a lack of a competitive health insurance market all contribute to the gaps that affect all Connecticut residents.

The BPWG also identified several initiatives in Connecticut that could serve as the basis upon which to address gaps and to build a more high performing health system. These initiatives include:

- the State Employee Health Plan's Health Enhancement Program;
- Medicaid's care delivery and payment innovation: person-centered medical homes and Health Neighborhoods;
- provider practice transformation initiatives such as patient-centered medical homes (PCMH), Accountable Care Organizations (ACO), etc.;
- establishment of the Health Information Technology Exchange (HITE-CT);
- start-up of HealthyCT, (a non-profit CO-OP health plan expected to be operational in October 2013); and
- private sector value-based initiatives being implemented by both purchasers and payers.

The BPWG concluded that the key to addressing the gaps for uninsured and underinsured individuals and small groups is for Connecticut to fully embrace the creation and adoption of a value-driven health system for all its residents. As an underlying principle, a value-driven system could serve to align the activities of all segments in the state working to implement reform and serve to organize, integrate and guide all HCC work group recommendations.

High Value in Health Care

The BPWG found Michael Porter's definition of what constitutes a high value health system to be useful in guiding its recommendations to the Health Care Cabinet. According to Porter, (see citation for article by Porter in Appendix C) *"… **value is defined as the patient health outcomes achieved per dollar spent. …..If value improves, patients, payers, providers, and suppliers can all benefit while the economic sustainability of the health care system improves. ….The best way, and perhaps the only way, to improve the equity of care is to measure value, make value transparent, and reward value improvement. "***

Key hallmarks of a value-driven system include payment to providers that is based on actual health o*utcomes*, not the volume of services delivered. Results in patient outcomes and quality are evaluated relative to their cost. The system achieves high value when patients are engaged, actively participate in improving in their own health and have equal access to choices of affordable coverage and care.

Recommendations

The Business Plan Work Group makes the following recommendations in the spirit of addressing the root causes of the problems of access, affordability, quality and sustainability. For each recommended goal set, we offer a statement of rationale or need and supporting strategies.

Goal:

1. **Diversify the Connecticut insurance marketplace to expand access to coverage, enhance the patient care experience, improve health outcomes, emphasize wellness and prevention, and control costs by:**
   - **Promoting new health plan entrants including nonprofit, public, and/or private health plans**
   - **Coordinating and leveraging the State's purchasing and regulatory power to influence existing health plans to adopt a value health strategy**
   - **Evaluating the efficacy of State convening authority to further this goal**

Rationale:

- Connecticut health plan value-driven initiatives are emerging but are limited and fragmented
- Markets in other states with local, non-profit health plans are innovating in plan design and payment methods for the purpose of creating long term member value
- Purchasers must ultimately be committed to driving change by partnering with payers and providers and collectively sharing accountability for creating a value-based health system
- Other states are beginning to use executive and legislative vehicles to achieve cost transparency and set cost reduction targets (see citation for complete article by Ayanian & Van der Wees in Appendix C)

Supporting Strategies

- Use all available vehicles –executive, legislative, regulatory, private, public, nonprofit, philanthropic -- as levers to promote implementation of a value health strategy
- Promote all stakeholders' work toward:
    - True partnership and alignment between public and private purchasers, insurers, providers and consumers
    - Payment arrangements that reward and promote value
    - Delivery system innovations
    - Price transparency
    - Quality metrics and evidence based practice
    - HIT to support the effective care delivery, coordination and performance measurement required of a value health strategy
    - Increased education of individuals and small group markets
    - Integration of medical, behavioral health and dental health services & coverage

Goal:

2. Establish qualifying criteria for plans to be offered in Connecticut's Health Insurance Exchange that promote a value health strategy over the long term.

Rationale:

- The Exchange has the potential to offer more than 150,000 new Connecticut consumers access to health insurance; the Exchange can leverage its position to drive value and innovation.
- Connecticut is one of a growing number of states publicly developing a health insurance exchange; other states are quietly developing health insurance exchanges. This provides

an opportunity to exercise and demonstrate leadership nationally, and position our state for investment by the federal government and/or possible entrance into the market by new competitors. New entrants that focus on value would provide competition in the Connecticut insurance market currently dominated by a small number of insurers.

- Require participating health plans to commit to a long-term value-based approach, to ultimately bend the cost curve and make health insurance more affordable over time. The move to a value approach may have to be phased in, recognizing the near term need for an adequate number of health plan choices in the Exchange.

Supporting Strategies:

Design and operate the Exchange as a business that is driven to serve the needs of individuals and small businesses as its primary purchasers.

- Develop simple enrollment tools that allow easy access to qualified health plans while determining subsidy eligibility and maintaining quality controls.
- Employ user-friendly communication capabilities to reach intended market segments (literacy, culturally and linguistically appropriate).
- Solicit ongoing input from consumers and small employers participating in the Exchange in order to understand and be responsive to their definitions of value.
- Engage navigators, brokers and agents among others to educate, inform and support consumers.

Design and operate the Exchange to ensure that health plans participating in the Exchange derive value.

- Make it easy for health plans to participate and compete.
- Lower administrative burden (facilitate enrollment and premium collection).
- Phase in value based delivery system and payment innovations intentionally and systematically.
- Work with providers, health systems and purchasers to achieve this goal.

Goal

3. Address the gaps in access to affordable, quality care that will continue for certain groups, even with the implementation of the ACA.

Rationale:

Estimated premium share and out-of-pocket costs in the Exchange will be an economic burden to individuals between 138 % and 200% of the federal poverty level (FPL). Immigrants, both those lawfully present and those who are undocumented, will also face significant coverage gaps (See Appendix B for BEST Report; Mercer analyses).

- Legal immigrants here less than 5 years will be allowed to purchase coverage through the Exchange in 2014. However, adults in this group with income in the Medicaid range will still not be permitted to enroll in Medicaid. Therefore, some lower income legal immigrants here less than 5 years, while eligible for federal premium and cost-sharing subsidies offered in the Exchange, will likely find these subsidies to be insufficient, as they are based on incomes above the 138% of federal poverty level (FPL) maximum for Medicaid eligibility.
- Undocumented immigrants are not eligible for coverage through the Exchange, either with or without subsidies, or through Medicaid.
- Small groups and individuals may have difficulty finding affordable quality coverage unless cost drivers are addressed.
    - Premiums are likely to rise for many small businesses and individuals. Mercer findings show that 47% of small groups and individuals (respectively) currently buy insurance that has an actuarial value below the minimum 60% actuarial value required by the ACA.
    - The early experience of the Massachusetts exchange, known as the Connector, indicates that very small groups may not find the Connecticut Exchange plan offerings affordable. The Massachusetts Connector is now phasing in value driven reforms to lower costs and make coverage more affordable.
- To the extent any group is un- or under-insured, costs are shifted to everybody else.

Supporting strategies:

Establish the commitment by all relevant stakeholders to ensure needs of the State's populations most at risk for being uninsured are being addressed.

- Determine the feasibility of the State Basic Health Program (SBHP) option under the ACA to address significant affordability and access problems for Connecticut residents between 138% and 200% FPL

    - The Office of Health Reform and Innovation's work group should identify strategies for ensuring sustainability of SBHP.
    - PA – 11-58 requires the Cabinet, in consultation with the CEO of the Exchange and other relevant stakeholders to make appropriate recommendations about the BHP
        - Identify risks and benefits of SBHP.
        - Identify alternatives for serving this population should SBHP prove impractical.
    - If BHP is enacted, leverage Medicaid's delivery system and payment reforms to advance a value health strategy for the State Basic Health Program – the healthier people stay, the more high-cost care can be avoided.
- Strengthen the provider safety net by assuring sufficient funding, access to expertise and care coordination support to Access programs, free clinics, community health centers and other providers of care to underserved populations.
- Offer small groups and individuals sufficient choice of affordable value-driven nonprofit and for-profit plan options within and outside of the Exchange. The cost of health care issues must be addressed in order to increase uptake by small groups and individuals

Goal

4. Ensure a trusted and effective forum exists for public agencies and the private sector to collaborate on identifying solutions and innovations in health care.

Rationale:

- Efforts at a value health strategy are underway in public and private sectors, but they require focused attention and collaboration to enhance learning, coordination and impact.
- Information to measure outcomes, cost and quality is not readily available.
    - An All-Payer Claims Database is clearly needed to provide baseline and trend information on health service utilization. Commercial insurers do not readily share claims experience data for small groups or individuals.
    - Medicaid and the State Employee Health Plan are focused on data collection and analysis and need more resources for these efforts.
    - In both public and private spheres, there is very little clinical outcome data to correlate with claims data.
    - Support integration of data across public agencies addressing health.
- Connecticut could accelerate the creation of a value-driven health system by leveraging its wealth of internal resources (academic institutions, provider organizations, large employers, health plans, CT Business Group on Health, State agencies, brokers, advocates, and others).

Supporting Strategies:

- Charge the Office of Health Reform and Innovation to perform this role effectively by providing it with the resources and leadership support, responsibility for and accountability to effectively:
    - Bring together stakeholders to ensure ongoing engagement in the development of a value health strategy, including consumers/patients, providers/ hospitals, employers/payers, and State agencies.
        - Build and maintain broad and deep community stakeholder connections
    - Facilitate the development by relevant stakeholders of a set of population and systems level health outcome results and metrics to measure progress toward achieving a high value health system
        - Continuously monitor the percent of uninsured, and analyze who is uninsured and underinsured and why.
        - Establish performance requirements for State contractors congruent with outcomes, access, equity and cost reduction goals in pursuit of a high value health system
        - Monitor, evaluate and report on results
        - Track innovation within Connecticut and facilitate measures to promote acceleration
            - Collect and disseminate best practices to all stakeholders; host a learning community
        - Pursue and leverage all governmental, private and philanthropic funding opportunities
        - Achieve integration of initiatives and data to better serve Connecticut residents

Final Summary

This report from the Business Plan Workgroup to the Health Care Cabinet, the Governor and the Legislature makes a set of recommendations with the underlying goal of improving the physical, mental, and oral health of all Connecticut residents through ensuring that all residents have access to affordable, high quality health insurance coverage options. Underlying the specific recommendations and their supporting strategies is the assertion that adoption of a value-driven health system that provides incentives for all payers and providers, public and private, to focus on health outcomes per dollar spent on health care will result in lower costs and better quality for all Connecticut residents. We recommend that the State of Connecticut use its considerable purchasing, regulatory power and ability to bring people together, to leverage the implementation of delivery and payment reforms that will promote a high-value health system. Finally, our recommendations maintain that establishing a diverse insurance

marketplace in Connecticut will be key to encouraging innovation in value-based benefit design, engaging consumers, and realigning payment and delivery models in order to produce higher quality and lower cost benefit plans and health care services.

Appendix A

Health Care Cabinet Operating Principles

(Approved December 8, 2011)

1. Commitment to Impact: Contribute to the improved physical, mental, and oral health of all Connecticut residents as seen in the following:
a. The number of individuals and/or constituencies affected
b. The depth and/or intensity of the problem
c. Reduction of barriers and burdens for those most vulnerable
d. The time frame in which change can occur
e. The cost effectiveness of health and health care purchasing that promotes value and optimal health outcomes.
f. A health insurance marketplace that provides consumers a competitive choice of affordable and quality options**.**

2. Equity in health care delivery and access: Recommendations are mindful of the goal of reducing disparities based on race, ethnicity, gender, and sexual orientation.

3. Leverage: Recommendations must:
a. Make the best use of past and current knowledge and expertise
b. Maximize the opportunities provided through initiatives from the public and private sector.
c. Be informed by data and evidence-based practice and research.

4. Accountability: Be fully accountable to the public in a transparent process that meets the objectives of Public Act 11-58.
a. Identify and measure outcomes that demonstrate meaningful results
b. Maintain consumer-driven goals throughout the process

5. Inclusion: Ensure that there are meaningful opportunities to obtain a broad cross-section of views, with particular emphasis on the perspectives consumers, communities, small business, and providers.

6. Action: All recommendations must take into account implementation and position of Connecticut to seize opportunities.

Appendix B

Resources and Experts consulted

Presentations

- **CDPHP® Health Value Strategy and the Commercial Markets**
  John D. Bennett, MD, President & CEO and Robert Little, Vice President Underwriting, Capital District Physicians Health Plan (Presentation to full Cabinet)
- **Products and Marketing Approaches from the Massachusetts Connector**
  Stephanie Chrobak, Director of Operations, Massachusetts Connector
- **Lessons Learned from the Massachusetts Health Connector**
  Kevin J. Counihan, President of CHOICE Administrators Exchange Solutions, formerly Chief Marketing Office Massachusetts Connector
- **CO-OPs and ACOs**:
  Kenneth Lalime, Executive Director, CSMS IPA
- **The Basic Health Program- What would it mean for Connecticut**
  Katharine London, UMASS Medical School Center on Health Law and Economics
- **Employers' Role in Health Care**
  Laurel Pickering, President & CEO ,Northeast Business Group on Health
- **Small Group Market Roundtable**
  Antonio Pinto, member, SHOP Advisory Committee, CT Exchange
  Philip Boyle, Vice President, Pierson & Smith (*BPWG member*)
  Linda St Peter, Broker Owner, IBIS Commercial Investment Real Estate (*BPWG member*)
- **Overview of Connecticut's Uninsured and Underinsured**
  Ellen Andrews, PhD, Executive Director, Connecticut Health Policy Project (*BPWG member*)
- **Providing Services to the Low Income Population in Waterbury**
  Leslie Swiderski, Program Coordinator, Program Access, Waterbury
- **State Employee Health Plan Health Enhancement Program**
  Thomas Woodruff, Ph.D., Director, Healthcare Policy & Benefits Administration at State of Connecticut (BPWG member)
- **PCMH: A Rebirth of Primary Care**
  Robert Zavoski, MD, MPH, Medical Director, Connecticut Department of Social Services

- **Recommendations of the SustiNet Board Final Report 2010**

Jill Zorn, MBA, Senior Program Officer, Universal Health Care Foundation

- **Speaker's Small Business Task Force Report**

  Vicki Veltri, JD, LLM, State Healthcare Advocate (*BPWG member*)

Additional Perspectives Solicited

- Anne Melissa Dowling, CFA, Deputy Commissioner at Connecticut Insurance Department
- Jamesina Henderson, CEO, Cornell Scott Hill Health Center
- Jewel Mullen, MD, Commissioner, Connecticut Department of Public Health
- Kate McEvoy, Interim Director of Medical Administration, Department of Social Services
- Keith Stover, Lobbyist, Robinson & Cole LLP
- Kevin Galvin, Small Business for a Healthy Connecticut
- Mary Ellen Breault, Connecticut Insurance Department
- Paul Grady, Partner, Mercer
- Robert Tessier, Executive Director, Coalition of Taft-Hartley Health Funds
- Todd Staub MD, Board Chairman, ProHealth Physicians

Consulted Resources

- American Community Survey Data, *Last Revised: September 25, 2012*
- Basic Health Program Analyses, University of Massachusetts School of Medicine Center, *April 2, 2012*
- Best Economic Security Tables (BEST) Report, *April 2012*
- CDPHP: Health Value Strategy and the Commercial Markets, *May 16, 2012*
- CHOICE Administrators Report on Health Insurance Exchanges, *December 22, 2011*
- Connecticut Health Policy Project Report, *December 12, 2011, update January 23, 2012*
- Connecticut State Medical Society-IPA, Inc. Report on CO-OPs and ACOs, *April 30, 2012*
- Final Report of the SustiNet Board to the Connecticut State Legislature, *January 2011*
- HUSKY Enrollment reports, *updated September 20, 2012*
- Massachusetts Health Reform: A Five Year Report, Alan G. Raymond, *November 2011*
- Medical Expenditure Panel Survey
- Mercer Consulting reports to the Board of Directors of the Connecticut Health Insurance Exchange Authority, *December 15, 2011*
- National Association of Health Underwriters
- Office of Policy and Management Low Income Adult (LIA) Data
- Presentations to Health Care Cabinet made by Delivery System Innovation and Health Information Technology Workgroups
- Speakers Working Group on Small Business Health Care: Report and Recommendations
- Universal Health Care Foundation of Connecticut Small Business Survey (*2012*)

Appendix C

What Is Value in Health Care? Michael E. Porter, Ph.D, New Engl J Med 2010; 363:2477-2481, December 23, 2010 http://www.nejm.org/doi/full/10.1056/NEJMp1011024

Tackling Rising Health Care Costs in Massachusetts, John Z. Ayanian, MD., MPP and Philip J. Van der Wees, PhD, New Engl J Med 2012; 367:790-793, August 30, 2012 http://www.nejm.org/doi/full/10.1056/NEJMp1208710