Advisory Commission on Intergovernmental Relations

GAE Conference Room, Legislative Office Building
210 Capitol Ave, Hartford, Connecticut

Thursday, April 19, 2012 - 10:00 A.M.

Members Present: Bruce Wittchen (acting Chairman), Sen. Stephen Cassano, Jim Finley, Frank Nicastro, Mark Paquette, James O'Leary, Leo Paul, Scott Shanley and Joyce Stille

Members Absent: Mark Allaben, John Finkle, Ronald Harris, Barbara Henry, Robert Kaliszewski, Linda Krause, Alice Meyer (Vice-Chairman), Virginia Seccombe and Michael Stupinski

Staff: Bruce Wittchen

Other Attendees: Beth Cook, Mary Eberle, Ann Ferris and Carl Stephani

Opening Remarks: Due to the presence of four other attendees, Bruce Wittchen asked everyone to introduce themselves. He then noted that a quorum was not present because of the day's busy legislative schedule. Since the group would be unable to conduct normal business and additional members will be pulled away for other meetings as the morning progresses, Bruce recommended the group proceed directly to agenda item 4a, a presentation about CT's Health Benefit Review Program.

1. **Consideration of Minutes of January 26, 2012 Meeting:** A quorum was not present and the January minutes were not considered.

2. **Consideration of ACIR reports:** There were no reports to consider.

3. **Old Business:** There was no old business.

4. **New Business:**

   a. CT Insurance Department (CID) – Health Benefits Review Program: Ann Ferris of the UConn Center for Public Health and Health Policy (CPHHP) described the Center and some of the services it can offer, including data networking and program evaluation. She noted that the Center is a national model, with small business spinoff potential. Ann then introduced Beth Cook of CID who began a PowerPoint presentation (see attached).

   Beth Cook described PA 09-179, which initiated the Health Benefit Review Program. She explained that 30 states require some level of review and that some require such review before such mandates are adopted. She said the costs of the program are assessed against health insurers and noted that it is a cost the insurers do not mind paying.

   The CID contracts with the CPHHP, as directed by PA 09-179, to assess mandates and proposed mandates on the basis of 25 criteria. Maryland and California are among the best state programs, along with CT and CA funds full-time staff for its program. CT's program is funded on an as-needed basis, so CPHHP cannot permanently assign staff to the program. The challenge for the first year of the program had been to review all mandated health benefits then in existence.

Beth explained that there are three criteria for identifying a mandate. A mandate can require coverage of services by a particular category of health care provider; require coverage of screening or services for a particular condition; or it can require coverage of particular types of services or supplies. If any of the three is required to be covered by health insurance, the requirement is a mandate. Pre-existing conditions are not considered in this process.

Beth Cook said mandates have a life cycle – they are proposed by someone, become a requirement for insurance coverage and then become the standard of care, so are no longer necessary. Health care evolves and a mandate can end up being no longer necessary. One goal of this review process is to clean up mandates and repeal those that are no longer needed. Beth noted that the CID takes no position on proposed mandates when testifying at the legislature, but explains the potential financial impact or conflicts with other laws.

Beth Cook explained that recent state interest in health insurance mandates resulted from concerns about federal health insurance law that defined essential health benefits and would require states to assume costs of additional state-mandated benefits. The initial federal restriction was relaxed so that states will not be responsible for the costs of mandates in place by 12/31/2011, but the state will be responsible for costs resulting from future mandates.

The CID is recommending the state be cautious about new mandates that extend beyond the 12/31/2011 benchmark or beyond the existing standard of care. This concern has been reflected in the Office of Fiscal Analysis reports provided to legislators.

Commission member O'Leary asked how the cost of newly mandated services would be paid and Beth Cook said that the increased cost would appear in insurance premiums. Commission member O'Leary asked how it would apply to Medicare and Beth said Medicare, Medicaid and self-funded insurance coverage are not subject to state health insurance mandates.

Mary Eberle said the mandate review process begins when the Co-chairs of the Insurance and Real Estate Committee send a request for review of identified proposed or existing mandates to the Insurance Commissioner and CID submits the request to the CPHHP. Medical library staff perform an initial literature review and, concurrently, the program requests information from insurance companies and managed care organizations. The program also reviews national and state databases and interviews relevant providers and vendors.

In addition to researching factors specific to commercial insurance coverage, the program assesses whether alternative sources of coverage or funding are available for the specific service, condition or product. However, such alternatives are typically only available to people lacking insurance, so have little or no impact on the cost of the insurance mandate.

Data are provided to actuarial consultants for detailed analyses, but only after information that might identify individual people or insurance companies is removed. Mary Eberle said the program submits a report to the Insurance Department by mid-December describing the financial and social impacts of each mandate, including a full actuarial analysis of the prevalence of the service or condition being addressed and its impact. In assessing costs, they do not include indirect costs, such as those resulting from blindness

could be attributable to inadequate control of blood sugar if not for diabetes mandates. The Insurance Department submits the report to the Insurance Committee by January 1. The report is also posted online on the Insurance Department's website.

Beth Cook mentioned mandates have been proposed to serve the needs of one person and Ann Ferris added that the reports also discuss the medical evidence for a particular service. Commission member Nicastro asked if someone contacts the legislature to learn a mandate's origin. Mary said they research the legislative history and sometimes track a mandate back to its original sponsor. Commission member Nicastro recommended they meet with legislative leaders in advance to discuss these.

Beth Cook explained that the concerns raised by Commission member Nicastro demonstrate the advantages of pre-session evaluations, but most do not go through that process. Mary Eberle added that California's process does function that way and Commission member Nicastro asked for additional information about the CA program, which Mary will distribute. Beth agreed that it would be better if they could review proposed mandates prior to passage.

Commission member Paul said the state should assess all such mandates because even his self-funded program, which is not subject to such mandates, faces pressure to match commercial policies. Mary Eberle said the report can help municipalities evaluate their self-funded plan costs. Scott Shanley said comprehensive coverage is a marketing tool for town hiring and Mary agreed that people gravitate to plans with broader coverage.

Mary Eberle said the difficult question is how to decide which mandates are worthwhile. Beth noted that one perspective is that mandates should only be imposed when the service to be provided is a medical necessity. Commission member Shanley said mandates should be reduced when a particular service is no longer medically appropriate. Beth Cook referred to recent changes in mammogram and PSA recommendations that would reduce costs and noted that current insurance costs are based on previous recommendations. She added that it is difficult to evaluate new services because relevant data are limited.

As an example, Mary Eberle mentioned the mandate requiring 48-hour hospitals stay for maternity and mastectomy patients. She said that those mandates set a high standard of care that might not be needed in all cases, in part because of improved technology and changing medical protocols, but also because of the disadvantages of remaining in hospital longer than necessary. Nevertheless, doctors can be unwilling to discharge patients earlier than that because of concern that it could be interpreted as violating the expected standard of care.

Beth Cook said some health benefit mandates extend beyond expectations for health insurance coverage. She noted that the Lyme disease mandate (CGS 38a-518h) requires coverage for the controversial practice of long-term antibiotic use and mentioned that a provision in another statute (CGS 20-14m) shields a physician's prescription practices for Lyme disease from ordinary scrutiny. She added that the autism mandate (CGS 38a-514b) includes requirements for non-medical care.

Mary said five mandates, account for 12% of the total estimated cost of all health benefit mandates. The most costly is CGS 38a-542's mandated coverage for tumors and leukemia. Mary noted that policies routinely provide coverage beyond the obsolete $500

requirement for tumor surgery. She added that obsolete requirements of some mandates can be counterproductive. Beth mentioned a recently-removed requirement in CGS 38a-514 that did not require coverage for a residential substance abuse and eating disorder treatment unless that treatment followed a hospitalization of at least three days.

There was a discussion of the mandate for psychotropic drug coverage in CGS 38a-476b and Mary Eberle said physician groups need to address the standard of care that the mandate is based on. Beth Cook said there needs to be a better balance between physicians and various advocacy groups. There was a discussion of formularies and of the role of pharmaceutical companies in this process.

In explaining the importance of the program's mandate reviews, Mary Eberle explained that a mandate requiring expensive treatment for a rare condition can have a smaller effect on insurance rates than a mandate requiring inexpensive treatment for a more prevalent condition. The program's detailed evaluation of mandates provides the reliable information necessary to make decisions regarding proposed or existing mandates.

Beth Cook said mandate reviews cost an average of $50,000 per review and the total to date for the benefit review program is $3.1 million. Mary Eberle added that California insurance companies provide annual funding of $2 million to operate California's Health Benefit Review Program, which includes permanent staff. CA and CT both require reviews be done within their university system and the CT Insurance Department did not want to be placed in the role of doing such analysis.

Commission member O'Leary asked if the mandate reviews also look at factors leading to the overall escalation of health care costs. Mary Eberle said that is beyond the scope of this program, but the actuaries say technology drives much of the cost, with an MRI costing 10X more than an X-Ray. She added that health care providers have a financial incentive to do more, not to do less.

Commission member Paul asked if malpractice claims also have a role in driving the cost increase and Mary said they do. Beth Cook added that a lot of the discussion regarding health insurance is how to do more with less, but tort reform is also necessary. There was a discussion of the level of disagreement among people about the appropriate level of care for elderly people and the role of Do Not Resuscitate orders (DNRs).

Ann Ferris said the Center for Public Health and Health Policy is doing research in this area, looking at health outcomes and costs. They are bringing in health economists and health insurance actuaries. Beth noted that some people have very rich benefit plans with little cost sharing while some people have bare bones plans with significant cost sharing and there was a discussion of federal law.

b. 2012 Legislative Session: There was no discussion of the legislative session.

5. The next meeting will be at 10:00 AM, June 28, 2012, in the Mountain Laurel Room, Memorial Hall, CCSU, New Britain.

Connecticut Health Benefit Review Program

Connecticut Department of Insurance
and
University of Connecticut
Center for Public Health and Health Policy

Health Benefit Review Program

- Public Act 09-179 (CGSA §38a-21) established HBRP in Dept of Insurance
  - 30 states have some level of review required
- Existing and proposed health insurance benefit mandates
- Costs assessed to domestic insurers/MCOs
- 25 criteria
- Contract with UConn CPHHP to do reviews

University of Connecticut
Center for Public Health and Health Policy

Establishment of HBRP

- MOA between Department and CPHHP
- RFP and contract for actuarial services
- Requests from Insurance and Real Estate Committee by August 1
- Reports due to Committee by Jan. 1
- Existing mandates to be reviewed by January 1, 2011

P.A. 09-179

- Mandate definition:
  - An existing or proposed statutory obligation to provide coverage for:
    - Treatment or services from a particular type of health care provider
    - Screening, diagnosis or treatment for a particular type of disease or condition
    - Particular types of health care treatments or services, including medical equipment, supplies or drugs

CPHHP Reviews

- Mandate requests received from Dept.
- Work group reviews requests and assigns responsibility for each one.
- Work group sends request for initial research to UCHC medical librarians.
- Data request drafted and transmitted to insurance companies and MCOs.
- Actuaries develop data from own claims database and from insurer/MCO submissions.

CPHHP Reviews

- CPHHP researchers gather data from various sources to respond to criteria listed in

  P.A. 09-179:

  - Internet searches
  - State agencies
  - Federal and state data sets
  - Library searches of scientific literature
  - Various health, economics and education databases
  - Interviews with medical faculty and other health care providers

CPHHP Reviews

- Library research
  - Peer reviewed journals in last 10 years
    - Systematic reviews
    - Randomized controlled trials
    - Meta-analysis
    - Clinical trials

CPHHP Reviews

- Interviews
  - UCHC faculty
  - Other UConn faculty (Nursing, Pharmacy, etc.)
  - External health care providers

CPHHP Reviews

- Actuarial Reports
  - Claims and other data from insurance companies and MCOs
  - Claims data from proprietary databases of actuarial consultant
  - Consultation with staff doctors

CPHHP Reviews

- Reports
  - Library research
  - Actuarial report
  - Interviews with medical faculty
  - Other research

Organization of Reviews

- Standard format
  - Overview
  - Background
  - Methods
  - Social Impact
  - Financial Impact
- Executive Summary and
  General Overview for each volume

Organization of Reviews

- Appendices
  - P.A. 09-179
  - Letter of request from Insurance Committee
  - Language of statute or proposed bill
  - Actuarial report
  - Glossary

Sample Reviews

- Existing mandate:
  Diabetes testing and treatment (§38a-518e and §38a-492)

- Proposed Mandate:
  Thermography for breast cancer screening

2010 Executive Summary

- Existing mandates account for 22% of group premium and 18% of individual premium.

2010 Executive Summary

- Five mandates account for 12% of group premium:
  - Tumors and leukemia (§38a-542)
  - Mental health (§38a-514)
  - Psychotropic drugs (§38a-476b)
  - Diabetes testing/treatment (§38a-518d)
  - Newborn coverage (§38a-516)

2010 Executive Summary

- Next five mandates account for 5% of group premium:
  - Colorectal cancer screening (§38a-518k)
  - Off-label use of cancer drugs (§38a-518b)
  - Infertility (§38a-536)
  - Mammography (§38a-530)
  - Chiropractors (§38a-534)

2010 Executive Summary

- Remaining 35 existing mandates account for 5% of group premium

CT Health Benefit Review Program

Questions?