



STATE OF CONNECTICUT  
LIEUTENANT GOVERNOR NANCY WYMAN

Health Care Cabinet:  
Business Plan Development Work Group

Thursday, May 24, 2012  
Meeting Minutes

**Business Plan Work Group Attendees (4):** *Frances Padilla, Co-Chair; Nancy Yedlin, Co-Chair; Phil Boyle; Linda St. Peter*

**Absent (6):** *Ellen Andrews; Bonita Grubbs; David Guttchen; Alex Hutchinson; Vicki Veltri; Tom Woodruff*

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**Welcome and Introductions, Review of Work Group Charge**

Frances Padilla opened the meeting by welcoming everyone. Members introduced themselves.

The minutes from the April 30 and May 7 meetings were approved.

Ms. Padilla reminded members of the next work group meeting on June 4, 3:00pm-5:00pm, and the Health Care Cabinet meeting on June 12 at 9:00am, at which the work group's preliminary recommendations will be discussed.

Ms. Padilla then reviewed the charge of the work group:

*The charge to the Business Plan work group of the Cabinet is to propose one or more business models that could effectively offer quality health benefits affordable to small businesses and individuals. It will compile and analyze market, feasibility and risk assessment data in order to identify gaps in coverage, quality and affordability. The work group will develop multiple scenarios for addressing such gaps including public, nonprofit and private approaches, and it will make recommendations for alternative approaches. The Cabinet is responsible for transmitting recommendations to the Governor and legislature by October 1, 2012.*

**Discussion of High-Level Preliminary Recommendations**

Ms. Padilla began the discussion of the work group's recommendations by saying that they should be based on identifying gaps in the current health care system. One major gap relates to value, and the group should recommend a value-based strategy for outcomes and access. The presentations to the work group at previous meetings all emphasized the importance of value in health reforms.

Ms. Padilla then reviewed the draft recommendations, which are subject to change by the work group:

1. Provide plan options that maximize affordability and value; promote the triple aim (improving care, improving health outcomes, and reducing costs). These plan options should all include:
  - Payment incentives
  - Quality measures
  - Delivery system reforms
  - Partnerships between employers, insurers, and members
  - Public plans
    - Existing public plans
      - State employee health plan: self-insured, health enhancement plan, higher rates paid to patient-centered medical home practices
      - Medicaid: self-insured, developing payment incentives
    - Proposed expansion of public plans
      - State employee health plan: open to municipalities, nonprofit state contractors
      - Medicaid: Basic Health Plan (separate work group studying this option)
  - Private nonprofit plans
    - Possible new plans
      - CT State Medical Society CO-OP (applying for federal loans)
      - Nonprofit plan such as those from neighboring states (e.g. Massachusetts or New York)
    - Policies to encourage development of new nonprofit plans
2. Enhance capacity of the state (through the Office of Health Reform & Innovation), Exchange, public and private health plans, and providers to advance innovation, track progress, and monitor accountability through:
  - Data collection (All-Payer Claims Database)
  - Conducting surveys and data analyses
  - Care coordination
  - Reporting on success and progress of reforms
  - Setting standards for value
3. Address the needs of those that may still be uninsured, including undocumented immigrants
  - Coordination with safety net programs
  - Expansion of access programs

Phil Boyle said that the recommendations should consider the positive changes made by for-profit plans, including the adoption of ACO and PCMH models. Nancy Yedlin replied that nonprofit plans have different structures than for-profit plans, and as a result different relationships with employers, owners, consumers and providers. She said that these differences

should be taken into consideration, as well as the regulatory environment for health plans in Connecticut.

Also regarding the first recommendation, Mr. Boyle cautioned that while self-funded plans (e.g. large employers, the SEBP and CT Medicaid plans) provide opportunities to introduce innovation, these are not without risk. Others agreed and Ms. Padilla indicated that Mr. Boyle's point underscores the need to address cost and quality – through a value-based approach – regardless of the coverage funding mechanism.

Regarding the second recommendation, Mr. Boyle said that there is a need for comparative research data, with both claims and clinical information. Ms. Yedlin suggested that the state pursue grants and other opportunities to help fund these initiatives.

Ms. Padilla raised the issue of market research with regard to the Exchange. She said that Massachusetts studied its potential Exchange market, and that Connecticut should do the same. Linda St. Peter added that Connecticut should also look to Massachusetts for creative marketing ideas for the Exchange. Ms. Yedlin mentioned that under-insured people should be a focal point for the Exchange's outreach.

In considering the third recommendation, Mr. Boyle asked if the state had any data on care for undocumented immigrants. Ms. Padilla said that immigrants who have been legal residents for five years might be able to purchase coverage through the Exchange. Undocumented immigrants will not be able to participate in the Exchange. Ms. Yedlin and Ms. St. Peter both mentioned examples of physicians providing care without insurance for undocumented immigrants.

Ms. Padilla closed this discussion by saying that the recommendations are still a work in progress, and asked members to think about additions or changes.

### **Public Comment**

There was no public comment.

### **Adjournment**

The meeting was adjourned at 2:45pm.