

Connecticut Health Insurance Exchange Consumer Outreach Forum Provider Group Discussion Summary

Date:

February 29, 2012

Location:

Gateway Community College, 60 Sargent Drive, New Haven

Background:

Mintz & Hoke has been charged with developing the consumer outreach program for the Connecticut Health Insurance Exchange. A series of consumer outreach forums represent the initial steps in a multiple-phased information gathering process aimed at better understanding people's needs, desires and expectations relative to the Exchange. Input from participants in these group discussions, moderated by Mintz & Hoke, will have a direct impact on the development of messages and the tools used to introduce the Exchange and inform state residents about the options available to them. Recruitment for this forum consisted of an email invitation sent on February 17, 2012 and a second email invitation sent on February 22, 2012. This document is intended as a summarized snapshot of the initial perspectives shared by the individuals who participated.

This document is not intended to represent final thoughts or positions.

Moderators:

Chris Knopf, Mintz & Hoke
Andrew Wood, Mintz & Hoke
Kathy Morelli, Mintz & Hoke

Invited to Attend:

Consumer outreach forums were open to the public. Direct invitations went out to the following:

American Board of Podiatric Surgery
American Chiropractic Association
Avon Health Center
Community Health & Wellness Center of Greater Torrington
Community Health Center Association of CT
Community Health Center, Inc.
Community Health Resources
Conference of Churches
CT Academy of PAs
CT Academy of Physician Assistants
CT Association of Health Care Facilities
CT Association of Optometrists
CT Chiropractic Association
CT Community Providers Association
CT Community Providers Association
CT Dietetic Association
CT Hospital Association
CT Naturopathic Physicians Association
CT Nurses Association

CT Nurses Association
 CT Oral Health Initiative
 CT Pharmacists Association
 CT State Dental Association
 CT State Dental Association
 CT State Medical Society
 CT State Medical Society - Independent Practice Association
 East Hartford Community HealthCare
 Harbor Health Services
 Hebrew Health Care, Inc.
 LeadingAge
 S & S Management Services
 Southington Care Center
 The Kowalski Group
 West Hartford Health & Rehab Center

Meeting Attendees:

Carole Bergeron, CT Nurses Association
 David B. Dziura, American Chiropractic Association, CT Chiropractic Association
 Doug Keck, CT State Dental Association
 Edna Wells, CT State Medical Society – Independent Practice Association
 Jim Willians, CT State Dental Association
 Kate Galambo, Community Health Center Association of CT
 Ken Lalime, CT State Medical Society – Independent Practice Association
 Margaret Flinter, Community Health Center, Inc.
 Marie Spivey, CT Hospital Association
 Mary Anne O’Neill, CT Community Providers Association
 Tatiana Barton, CT State Dental Association

Consumer Perception:

As a healthcare provider, what are your current mindsets about the health insurance industry? What is affecting these attitudes?

In recent years, too much money has been taken out of the healthcare system and not reinvested. The present system is a game of what do you get for what price. Too many people come into my office not knowing what coverage they have for a benefit until they need it.

Even with predetermination of benefits there is no guarantee of payment. As a provider you are in the dark. When the customer gets upset with the amount they have to pay it is very disconcerting. Non-covered services legislation just passed for if there is a benefit you provide, and the insurance company does not cover it. If Ms. Jones comes in for a service and you provide it, there is a chance that you could be audited and either not get paid or reimbursed by carrier.

If you advertise a fee, customers want the same deal, whether or not it was just promotional.

Providers feel there is a lack of collaboration with insurers today. There are too many burdens. Providers feel insurers are trying to overpower them. There is a control issue. Production reimbursements, juxtaposed with the insurers' salary, it doesn't mesh well. This is causing independent practices to merge with larger hospitals. Lack of transparency.

Tendency to change all the time.

People consider the lack of care and high cost to a broken system.

Cost shifts. Consumer feels, "It's costing me more and more." They most likely blame the insurer first.

Providers get blamed first.

It's economic based. I would not necessarily say the providers.

The "healthcare industry" is too nebulous a term. Within that the enemy of efficiency for providers is the variation between plans, policies and procedures. Companies have very different attitudes depending on the client network. One insurer was able to make 300 changes to their contract when working with us, where a different provider only was able to change one aspect of their contract.

Neither physicians nor consumers feel like they have control. At one point as a consumer I was sure we had met our deductible, when the insurer felt otherwise. I felt I had no chance in winning that debate.

Why would the patient trust the provider if the provider is not able to confirm the cost that they will charge for their service? All of a sudden they get a bill for whatever. Payment assistance – everything is done actuarially – if everyone has insurance there is about 60% utilization. People don't understand that preventative care is covered about 95%, but once you are doing assertive care it goes down to 50% or is not covered. It is not the same type of coverage, so the provider's credibility gets undermined.

There are 10 essential health benefits. Dentistry is at the very bottom of the 10, and it qualifies as pediatric and vision. That pushes the whole adult dentistry out of the picture. Dentistry is in the category where some government plans include only some preventative measures. Most dental benefits are not catastrophic, it is more assistance. The idea from a dental perspective is to keep some sort of competition. There is dental and medical insurance, and the two do not mesh very well. They are coded and handled differently. Dentistry should not be left behind but it also needs to be equitable.

The public issue that I see is the cost issue. We talk about services needing to be reimbursed. \$3 trillion is a huge amount of money. If we don't get a handle on cost a lot of the good that this bill hopes to do will be thrown away. The coordination of care is something providers are working on right now. The patient becomes a more consistent cost patient when this is successful. If saved cost goes back to insurance company instead of going back to the public, that reverts us back to where we started. This is not going to change in a quarter; it's going to change in a generation.

Many CNAs in children's hospitals are on Medicaid because their pay is not enough. This is a group of people who are giving their all, and have skills, but they cannot afford to pay for insurance because of where they stand with income and healthcare coverage.

We do not have a shortage of dentists. 90% are open to new patients.

How do patients access healthcare when they do not have coverage? How does this differ from how clients who have coverage access healthcare? How does this affect your organization?

Community health centers are caring for the uninsured, but health centers have no place to send people for specialized care. The American Academy of Family Physicians offers help deciphering codes.

When you look at what was originally built, what kind of value did that have? How do you make sense out of all the negotiations? Is the policy that I have representing good negotiation? Does it represent the value of the service that I receive from the provider if they are not good negotiators?

In 2014, 40 million people are going to be added to healthcare laws. In the meantime, I would hope that there are measures to get us away from a \$7,000 day in the hospital setting. Hopefully we can lower the fees that people are paying so that access to care is affordable and appropriate. We are hoping the present system discriminates by license as they are supposed to under the law. People need access to insurance. They are going to have to defend the medical loss ratio. A lot of good is going to come of it.

50% of the uninsured are seen in community health centers. Some are seen in hospitals. Others stay out of healthcare until they must go to the emergency room. Others still use naturopathic medicine, acupuncture, and other types of healthcare. We know there are a lot of people still who will be left out due to citizenship status. Many people who are eligible will be left out due to availability of providers. These people are far more likely to suffer the consequences of chronic illnesses and preventable conditions because they did not get the primary care they needed. At health centers, people get a full application of preventive screenings. When people leave the doors of the health center, all that help stops.

The design of the Exchange needs to control for 'no-shows'. When someone does not show up for an appointment, it costs the doctor money. I think there needs to be some sort of penalty if they don't show up.

It should be the advocate to help them understand.

If I have 60% no-shows, maybe I am not going to participate in that plan anymore.

What are your perceptions about the forthcoming changes in healthcare insurance? How do you think these changes will affect your organization? How do you think they will affect your patients?

We hope that reform will bring changes.

When we first started in the HMO movement, insurers said, "Give us a discount, we will guarantee payment, and we'll pay it fast. We have a small network and you will get all the volume." Once the reform issues came along, we have brought out new products to find a way to get new patients involved. HSAs for example. Now you have to chase patients for the first \$5,000 deductible before the insurers get involved. We have reverted back to how it was years ago. We bring out great ideas and all the gains of doing that accrue to the insurer. It has eroded the trust between the providers and the financial backer. Everyone has a different policy and procedure for the same thing. When you get it wrong, you get dinged with "We can't pay for that because you did not fill out the form right." Hoping that this movement can improve that.

I represent community providers but I am an attorney. Because the law has been challenged legally so much, there is fear and uncertainty. There are some positive aspects, but no one really knows how all this is going to work right now.

We understand the value of integration of services, making sure when we talk about comprehensive care it is really inclusive of medical, dental and otherwise. The exchange represents an opportunity to do that. Leaving dental out is just a repeat of the same mistake that was made in 1965.

I just want to comment on the word “fair.” We need to think about what fair means to those of us who have good health insurance, in addition to the uninsured and underinsured groups we have been talking about. For folks who have insurance, they could have a relatively uninformed understanding of what is happening. They are accustomed to calling and being able to make an appointment. They are accustomed to a certain copay. How much are they willing to give up?

If it is perceived as a mandatory and it is less than fair, there will be anger about it.

What kinds of questions do you have about how these changes affect your organization?

We are apprehensive that there will be a change made that won't make a difference. I am suspicious of the motives of the insurance companies due to increasing costs. Despite good intentions, we risk creating a system that will leave us concerned about access to care. We do not have the practitioners we need for primary care. If specialists are not able to survive on the money they are being paid or are not incentivized to accept new referrals, it will be a major problem. Suspect many of the uninsured people are complicated, with multiple chronic conditions that will show up with something acute.

The concept that is difficult to grasp in the United States is that there is a finite dollar that we are fighting for, so we want to find the most effective way to do that. There needs to be competition. I do not want to see just one group vying for the dental dollar, or the OB-GYN dollar. Physician groups are trying to start a medical association. As a consumer I would like to see competition with the medical association. There is not enough competition in the dental market.

What is your current level of awareness of healthcare exchanges? What impact do you see this having on your organization?

We are very concerned to make sure the Basic Health Plan is sustainable, accessible, and affordable. Hospitals take care of people 24/7/365, in terms of Medicaid. The rates are so inadequate that the costs are shifted over to the employees and providers. Rates should be equitable to care for the needs of patients in the emergency room. If we are not getting the resources to pay for that, it has to get shifted somewhere else. The conversation needs to be inclusive of Medicaid.

The thought that specialists need to be paid at a higher rate in order to take patients is old paradigm. We need to change it so that the patients will be provided care regardless of rate. We have to change it so that the patient will be responsible for a certain amount and everyone else will be reimbursed based on the type of care provided.

We have \$47 million in prevention dollars to start. There is a crisis of cost. If there is no money then all of these great things will start getting whittled away. We need to keep those prevention dollars. We need people to understand that they need to take care of themselves through preventive care.

There are two different messages. “We are going to help you,” but also, if it is going to get me interested in what is this all about, “This is what is going to happen now.” A glossary of terms and common language needs to be there.

Establishing a Dynamic:

What do you think are the greatest challenges the Connecticut Health Insurance Exchange faces in consumer outreach efforts?

I don't think we bring people to us, I think we go to people. Whatever the marketing and education efforts are, we go out to them. That is how you build the trust. People are mobile, they are moving around a lot, especially those who are underinsured and poor. How do you do this in a way that gets information to people in the places where they are? How do you get to faith based communities, homeless shelters? Then build that trust by giving them information and getting feedback. Too many times we have professional planners instead of consumers at the table.

If there are problems, it will undermine your credibility.

What role do you think healthcare providers should play in the communications about the Exchange? How does this differ from the role healthcare providers play in communications about health insurance today?

As providers, we find that the most beneficial way to provide help to the consumer is by engaging with the patient through knowledge, whether the patient is engaged through their health plan, a family member, or otherwise. As an outreach problem, how do we as a community of caregivers connect that information with the consumer, engage them in the process, and then as providers, continue to support and enhance that?

You don't mind being a partner to your patient if you truly can understand their benefits.

How would you want your organization to be represented by the communications about the Exchange?

We tend to talk within our own groups instead of crossing boundary lines across different types of care. The sharing of information is incredibly important. The incentive is prevention for consumers as well as providers.

We all know change is coming, but we don't know what that change is going to look like because there is so much that is still in flux. We want to make sure we are included in the mix but we are not entirely certain we will be included.

What type of positioning do you expect your patients to be most responsive to?

I think it should have "insurance" in the name. That is the product you are buying. This is an education and selection process. It's important to have that in the name.

"Exchange" should be in there. That is what we are looking at, not Obama Care, not universal healthcare. That word is important. For me, "Exchange" means you have the ability to get your insurance from many options that you currently do not have the ability to have. It is an economic discussion.

What is “insurance”? Think about your car insurance. You pay the money and hope you never have to use it. We are not talking about insurance here, we are talking about coverage. Care. Preventive care. It’s not like we are putting money away and hoping never to spend it. Think new paradigm.

“Connecticut Affordable Insurance Program.” “Connecticut” should be in there. Connecticut had a choice to open this. Insurance I can take or leave. Affordability is key.

I have a visceral reaction to the word “insurance.” We are going to call it the same thing and say it’s different? The message needs to be nuanced. It needs to avoid the stigma that I am going to get the “leave-behind” care, looking like Medicaid.

Focusing the Message:

What elements of the Exchange do you think cause the most confusion or apprehension for you as a healthcare provider? For your patients?

Common language is key.

At the moment you need to be a lawyer to decipher that information.

You need a very clear motto. And three clear messages that everyone can understand, put them out there in all the languages and all the media. But you can’t do that if the thing you are selling is overly complex and complicated. I just joined Medicare, I got the book. I have a master’s degree and I am a registered nurse, and after five minutes I put the book down. It wasn’t worth reading due to all the caveats.

One of the challenges is that we are building from the ground up and it’s new. The message must be clear and created as simply as possible. You need to meet the needs of the consumer. There is a lack of trust. There must be choices.

What is the most important information the Exchange needs to make available to consumers?

Some sort of cost affordability in there.

One message that we haven’t pushed strongly enough is that separate from the Health Exchange, the biggest current issue will be gone: pre-existing conditions preventing people from getting coverage access. The consumer will be presented with something about gold, silver, and bronze plans. People are largely going to be deciding based on their pocketbook, whether their provider participates, and what they need. We need to treat all consumers with respect on this. When you have maxed out the subsidy and you are still expected to pay up to 4% of your income. You are not going to be able to talk about the Exchange without talking about the Basic Health Plan, even if it lives outside the Exchange. If not, we will have sold the lowest income people with the most to lose something that is not their most affordable option. Focus on that bronze level. Then the consumer will be able to decide between the bronze level, petitioning to not have any insurance, or going with the Basic Health Plan option. These people will certainly be likely to be lower income but not poor, working in a company but not provided high quality coverage.

The more the mandate gets discussed, the more there needs to be education. People do not understand right now how broken the system is. People only see one piece of it. They don’t understand that we are already paying for this, just in a different way. Educating them about what is happening right now, to help them better understand why the mandate actually is a good idea.

The incentive for people is to know that if you practice prevention. If you think something is going on with you, make that call and know where to make that call. We should get people excited about prevention.

Get these points out: this is a fair deal, and your provider is in it. The work the Exchange itself needs to do is make sure it actually is fair, because people will know whether it is or isn't fundamentally. The message should be memorable and understandable, so people get it. The educational, awareness piece is huge. But it must be true.

When we try to explain the value proposition, we have to have some detailed messages providing examples of the value. For instance, the patient who stays home longer than they should and ends up in the emergency room.

We need to provide concrete bullets illustrating what that value proposition means to a varied audience. How do we get the messages out to providers that this is a population that needs to be afforded the same consistent, fair and organized system that everybody else has?

If someone is going to take on that role, you have an incredible responsibility to coordinate care and do it right. That needs to be part of the design of the plan. It cannot be lax or you will fragment the system further. People are not being educated. Now people are going to get a credit card, so the education of the consumer's responsibility is paramount in our messaging.

What tone or personality do you think the Exchange should use in their messaging?

If it is going to be a mandate, utilize the mailing of forms. You are paying for it anyway, why not enroll.

We live in a leveraged market. If you are bigger you get more coverage, for example. Opportunity to convert market from a leveraged to a value market. What is the value proposition to the consumer? Why do I want to do this? I have access to care right now. In this disintegrated, disconnected model we have, the consumer has an obligation to be engaged. There is a value they can bring to the table to help us bring them service. There is value in getting engaged in this, so get them interested. We have to start with educating people why they want to do this. Is it worth 4% of my income? Cost versus quality.

Fair value means I am paying for something and I am getting something in return. If I want to make an appointment for care and I find out Exchange benefits are not covered for the first, second, third provider I go to, I will feel cheated. Access to what? Be able to see by who you choose, when you choose. Need to be able to access providers who are taking new patients. A good start is to have open panels and allow people to participate. When people buy insurance, they cannot see whether the providers in the network will be taking new patients. It is the responsibility of the Exchange to recognize credentials and pay the broadest range of providers across Connecticut so we do not run into that problem.

Once you convince people there is value in signing up for this program, and then they make the phone call and you disappoint their expectations, then you lose them. You must be sure that once you get them that far, you follow through.

The state, depending on your audience, is perceived either well or not so well. An independent entity going into it would not have that baggage. If handled well, there would be more credibility.

But it would not be good if the entity appeared to be another independent entity like an insurance carrier.

I don't think "brought to you by Obama Care" is going to work. It depends on the message about the brand. If the message is "we are an educator, we are your advocate, and we are on your side" those that need to access the Exchange will go there because there is perceived value. Then you win.

Vision/Approach for Outreach:

Who or what are your patients' trusted source(s) for information? What is the best way to leverage these sources to reach this audience? What role should ambassadors play in communicating the Exchange?

We never talk about the diverse cultures that are enriching our society today. Language has got to be included in anything we do. Keep focused on the differences and similarities. Be cognizant of disparities at this point. We have got to be sure that people understand what we are talking about. Different cultures, different languages, different populations that we are taking care of today. The marketing aspect really has to be aware of the level of language, different audiences, and different dialects even. How do we deliver care in the best way possible so that people understand and build that trust with their providers? We must be constantly aware of this as we build this. It is not just about money, it is about building awareness. Hospitals, community health centers, local health departments.

Their own experience. Their families. The woman in the house.

Organizations that they already belong to.

They do not trust mass media billboards from insurance companies.

The message would be best accepted from someone within the profession. Peer to peer education.

Public health and education. Providers as partners in the education of the public.

As we consider ways to publicize the Exchange, how do we reach small businesses beyond traditional media?

Younger consumers take social media as gospel. Websites.

To clarify what I said before, insurance company billboards may not be trusted. But they could be leveraged by the Exchange.

How can we make it easier for your patients to understand the Exchange and feel more comfortable with it?

With a common language.

Create consumer messaging that helps people understand the value, and helps them make informed decisions that they choose. The educational message to a Non-English speaking audience may be different from an English-speaking, middleclass person.

Through the school systems, faith-based organizations

We need consistency of messaging. Messages have to be continuous through implementation. Maybe you change the focus from here to there, but the education has to be continuous. There have to be resources to support that.

Education versus training. We need education for students (nursing, medical, and other professions) because they are now going out into their internships. They need to know something about the Exchange as well because they can get blindsided. Look at students in their 4th, 5th year.

What do you need to enable you to help consumers better understand the Exchange (i.e. communications, tools, education materials, etc)?

We need some consolidation of the message. If the provider doesn't know what the benefit plan looks like, we have to leave it up to the consumer to deal with the insurer. That disengages the consumer. If we allow the patient to determine where they need their care, we then have a fragmented system. There will be individuals, small business employees, and those right on the Medicaid/uninsured line who will access the Exchange. Consistency would be fabulous.

What can we do to help how the Exchange impacts your organization in a positive manner? Your patients?

I am a big fan of testing the market. Test it in Bridgeport, East Hartford, New Haven. Work out some of the kinks before you go. Education is incredibly important.

Test the provider market too. Primary Care Access Authority. We do not have a shortage of primary care physicians in Connecticut. It is about who participates in what based on reimbursement levels.

Describe what you would consider to be a successful outreach effort. What are the key elements that must be a part of the introductory outreach efforts?

If we get 5% of the population to change on day 1, I would be thrilled. If I can access the system better than I did yesterday.