

SustiNet Health Partnership

Preventive Health Advisory Committee

Co-Chairs

Michael Critelli
Cynthia Hodge

Board of Directors Liaison

Norma Gyle



Phone:

866.466.4446

Facsimile

860.297.3992

E-Mail

SustiNet@CT.Gov

Post Office Box 1543
Hartford, CT 06144-1543
www.ct.gov/SustiNet

Preventive Health Advisory Committee Regular Meeting

December 14, 2009

Meeting Minutes

Committee Attendees: *Cynthia Hodge, Co-chair; Michael Critelli, Co-chair; Dorothy Shearer; Norma Gyle; Pat Baker; Nancy Heaton; Carlos Sanchez-Fuentes; Joe Pandolfo; Steve Huleatt; Bob Krzys; Sharon Vallone; Sharon Langer; Tom Buckley; Jamesina Henderson; Marian Evans; Lynn Rapsilber; Stephanie Paulmeno*

Cynthia Hodge opened the meeting by welcoming members and having them introduce themselves. Norma Gyle briefly described what this Committee is expected to accomplish. She said that basically this act will make CT a model for addressing the healthcare insurance shortage/unavailability. Michael Critelli said that SustiNet legislation was designed to deal with three distinct populations: state employees and retirees; those needing safety net plans, such as Husky A and B, Medicaid, Saga and Charter Oak; and anyone who does not have employer based coverage or meets income criteria where the presumption is that the employer based coverage would not be affordable. He continued by saying that CT has an adjusted community rating system, meaning that rates can vary by three criteria within a licensed insurance plan, age, gender, or geography. Typically, this means that someone 55 years of age or older pays a great deal more than someone who is 25. Participating in a group plan will be more expensive if it has predominantly more 55 year olds. The end result is that many employers drop coverage when the costs reach a certain level.

The feeling in the general assembly was that a safety net was needed for people who were not poor or low income, but who were employed by a business that did not offer health coverage at affordable rates. SustiNet was created to design a safety net for all three of these populations, as well as providing scale in negotiating with insurance companies, as larger groups have more leverage for negotiating better rates with insurance companies. Michael pointed out that when speaking of insurance companies, he is referring to a third party administrator who is likely to be one of the licensed insurance companies, but if the state is going to be a self insured carrier, the SustiNet structure will be self insured. An unidentified speaker said that SustiNet legislation seeks guidelines for the development of a model

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benefit package, including public outreach and methods for identifying those who are uninsured.

Michael stated that there are three categories of prevention: primary, secondary and tertiary. Primary prevention means focusing on healthy and at risk people who do not yet have a medical condition. This would include issues relative to nutrition, exercise, tobacco usage, alcohol consumption, protection from injuries, and immunizations. Secondary prevention involves interaction with the healthcare system to conduct screenings for medical conditions, such as mammograms, colonoscopies, blood tests, etc. and to detect and provide early treatment. Tertiary prevention provides treatment after diagnosis of a chronic disease, to ensure that a disease management plan is followed, and to prevent a chronic condition from becoming acute or life-threatening. Tertiary prevention is not part of the charge to this Committee. Michael felt that the Committee should touch on obesity and smoking cessation, coordinating with those two Task Forces, but the Committee should focus on secondary prevention and those parts of primary prevention that are not explicitly included in the charges to the other groups. The Committee can also focus on oral health, mental health and integrative medicine.

Cynthia said that secondary prevention does not prevent disease, but targets treatment to prevent further injury. She also said that most insurance plans cover secondary prevention, and she felt that the Committee should focus on primary prevention because that area is most often not covered by insurance plans. An unidentified speaker asked if the charge to the Committee addresses children's issues separately from those of adults. Michael said that there are three different ways of looking at this. First, the Committee needs to decide if it will look at demographic characteristics such as children, geriatrics, prenatal, women, men, etc. individually. Secondly, the Committee must decide if it needs a different set of recommendations for the "safety net" population, the indigent, because that population has a different set of medical challenges. Thirdly, the Committee must decide if it wants to look at different geographies.

An unidentified speaker asked if the Committee would be addressing access to care. A different speaker said that the Committee would be creating a model benefits plan. She said that she felt that screenings should be part of primary preventive care. She gave an example, saying that in CT, newborn screening is provided for all babies who are born in hospitals. If something is found during the screening, and the child needs further treatment, this should be included in a benefit plan. This may be something else the Committee needs to address. She emphasized that the charge for the Committee is to make informed recommendations to drive the development of a benefits package. Continuum of care is essential, so the Committee will need to look at the whole healthcare system when making recommendations. She also said that the Committee needs to look at how existing plans are covering preventive services. Michael said that he wanted to address the question regarding access to care. He said that there are two types of access; one is access to insurance, which this Committee will address. The other type is access to healthcare professionals, which the Committee will not address. Michael also said that many people don't have primary care physicians, even those

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with generous insurance coverage. He asked the Committee if it was felt that in designing benefits, there should be a recommendation to have a primary care physician. (Unidentified speaker, inaudible, recording stops and starts repeatedly.)

An unidentified speaker said that the Committee should consider how much detail is put into the plan, whether a broad brush outline will be created or whether there will be specific outreach planned. Sharon Langer said that she had worked on the Health First CT Authority, which examined similar issues over the course of more than a year, so she suggested that report would prove helpful to this group to see what has already been done. Carlos Sanchez-Fuentes asked if there were any constraints, and also asked (inaudible). An unidentified speaker said that the purpose of designing the package was to improve health outcomes. She also said that there are constraints, but that the Committee can look at re-shifting dollars. She said that the Committee will need to look at putting an emphasis on prevention practices and benefits and enforcing them.

Michael said that he felt that the Committee will need to develop a very different strategy for outreach to the three populations mentioned previously. The third population described, those without employer based coverage or without the means to pay for employer based coverage, will be difficult to target because they are scattered all over the state. The “safety net” population is identifiable, but it is difficult to provide them with care because of many different obstacles, such as transportation, child care, conflicts with work schedules, etc. Inviting someone who has experience working with this population to provide education to the Committee on these issues would be valuable. He said that the Committee would also benefit if someone with an understanding of spending cap issues and the budget process could participate.

Michael said that with some spending, the payback is seen in a short time, for example seasonal immunizations, but with things like hypertension screening, the resulting savings might not be seen within a planned budget cycle. He also said that the US Preventive Services Task Force has created a list of the number of lives saved by following certain health practices; it is available online. That Task Force is probably the definitive federal governmental body in examining the economics and medical benefits of prevention; however, they didn't release information regarding what the payback time was for these practices. Aetna did a study on preventive screenings, plotting out from 0 - 3 years, charting what the payback time was. Michael felt that this study would prove to be valuable for the committee to review.

An unidentified speaker said that in the area of immunizations, CT is a universal vaccine state, which means that the state seeks to provide vaccines for every child in the state. The state tries to recoup some of the cost if the child is insured. If the child is not insured, the vaccine should be no cost, and doctors are only allowed to charge (inaudible). This is one area where CT is doing a good job. An unidentified speaker said that she had spent many years as a community health planner, and that she was struck by the primary role of prevention and getting access to care. There were three models that her organization studied

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at that time, one led by the Health Department, one led by the Community Health Center and one led by organizations such as United Way. An unidentified speaker said that some preventive services can be brought to children, for example in the schools, thus cutting down on some of the issues discussed previously, such as transportation, no shows, etc. Another unidentified speaker said that this method could cut costs by using a lower cost primary provider. An unidentified speaker said that CT is considered to be a leader in the country in school based health services and community health centers. She personally has worked with community health centers, and has found that they often aren't considered by the private sector to be a provider, so there are systems barriers that defeat some of the usage. This is an area that the Committee can work on; a redesign can help to maximize the population centered delivery system. She said that it is important to understand what exists now when choosing how to proceed.

Cynthia said that she thought it was important for the Committee to start thinking in terms of prevention that does not require interface with medical institutions. Those are the most inexpensive and get the greatest cost benefits. She gave the example of iodine and salt. There is no compliance required; by putting iodine into salt, people get the iodine that they need. She felt that this is the level that she sees this Committee working on, not on responding to diseases or getting people into a physician's office, but rather keeping people from getting diseases, providing incentives to keep them out of the physician's office. In dentistry, a good example is putting fluoride into water, which reduces tooth decay. The challenge is in providing access to fluoridated water to all people in CT. That cannot be part of a benefits package; however fluoride application could be part of a benefit package. The dental exam could include fluoride application. Cynthia emphasized the importance of staying focused on identifying benefits that are cost effective and that are within financial constraints. Insurers don't see things like fluoride application as being important. She continued by saying that the Committee will need to focus on those benefits that prevent disease but that don't come with a high price tag.

An unidentified speaker asked if it was within the Commission's charter to talk about regulations or legislation, for example, as New York City recently ruled on the anti transfat legislation or the labeling of foods. Aside from the obesity question, there are other reasons why it would be beneficial to label foods, for example listing the sodium content, which is important for hypertension control. An unidentified speaker said that she felt it was within the scope of the Committee to do this. Another unidentified speaker said that she felt that the co-chairs of the various Committees need to be in contact with each other. Many of these issues are of concern to more than one Committee or Task Force.

Tom Buckley said that he agreed with that viewpoint. He also said that he felt that cultural issues and/or health disparities will need to be addressed as part of this effort. He said that it was important to develop an outcome strategy so that people will use these resources and that these resources will be affordable. Michael asked that everyone send contact information to the co-chairs, and to also let them know what communication method is preferred. He also requested that members let him know what meeting day and time would

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work best, and he also asked for suggestions for where meetings could be held other than in Hartford. He said he would look at the suggestions sent and come up with a meeting schedule. Cynthia said that this Committee is facing a deadline of June 2010 for presenting a report of recommendations. She asked that everyone give some thought as to how the Committee should approach its charge.

Meeting was adjourned.

Next meeting TBD.

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