

Connecticut Health Care Reform Advisory Board

Final Report to Governor Rell and the General Assembly
June 30, 2010

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TABLE OF CONTENTS

INTRODUCTION

EXECUTIVE SUMMARY

HEALTH CARE REFORM ADVISORY BOARD REPORT

1. FEDERAL HEALTH CARE REFORM	1
The PPACA: A two-pronged approach to health care reform.....	1
Rising Health Expenditures.....	2
Health Insurance Coverage & the Uninsured in Connecticut.....	3
Connecticut in a National Context	4
Linking Service Delivery Reform and Payment Reform.....	5
Recommendations (Service Delivery & Payment Reform).....	6
2. HEALTH INSURANCE EXCHANGE(S).....	7
Role of the Exchanges in Federal Health Reform	7
State Exchange-Related Responsibilities	8
Recommendations (Health Insurance Exchange(s)).....	9
3. PATIENT CARE & HEALTHY CONNECTICUT	12
The importance of individual behavior	12
Healthy Connecticut.....	12
Primary care is critical to the success of federal health care reform	13
Existing entities are addressing health care information technology	14
Recommendations (Health and Wellness).....	15
4. MEDICAL LIABILITY REFORM	17
Growing consensus about the need for medical liability reform	17
Medical liability reform in health care reform.	18
Administrative Compensation System	18
Bifurcation of medical liability cases into liability and damages sections	19
Recommendations (Medical Liability Reform).....	20
5. COST ANALYSIS, FUNDING SOURCES, AND IMPACT ON CONNECTICUT'S ECONOMY.....	21

APPENDICES

A. Recommendations	23
B. Connecticut Residents' Insurance Status	27
C. ESI in Connecticut, by Employer Size	28
D. Impact of Reform on Business, by Employer Size	29
E. CMI Payment or Delivery Models for Consideration	30
F. Exchange Governance in Mass. & Utah	31
G. Health Insurance Exchange Overview.....	32
H. AHA Framework for Medical Liability Reform	33
I. Executive Order #30	34

INTRODUCTION

The national debate of health care reform has continued for many years, if not decades. With multiple stakeholders involved in the health care delivery system it seemed nearly impossible to reach agreement. In 2009, the health care issue remained in the spotlight as costs for insurance and health care services continued to rise and consumed 17% of the nation's Gross Domestic Product. In July 2009, Governor Rell acknowledged that congressional action may be approaching and issued Executive Order 30. This Order created a multi-stakeholder "Health Care Reform Advisory Board" (Board) charged with examining the federal legislation and making recommendations that are relevant to the citizens of Connecticut.

Through several vibrant and interactive discussions regarding the overall impact of the federal legislation on the health care system, a few common themes emerged with concerns focusing around: access to services, impact to premiums, and weak cost-containment measures. The Board repeated the message that simply having health insurance did not equate to having access to health care. The federal reform ensures access to health coverage by a large expansion of the Medicaid program. In Connecticut, access issues currently exist with lack of physicians accepting additional Medicaid patients into their practices and CT hospitals having financial challenges with the reimbursement rates. The multiple reforms to the insurance market concerned many Board members – although the individual mandate will exist, the penalties are weak yet the reforms to setting premiums are stringent; and that the cost-containment efforts will not be known until after all the reforms are in place.

This final report from the Board consists of several recommendations that have been identified as critical beginning steps. The Board realizes the breadth of the new legislation is far more expansive than this report, but is confident that providing timely recommendations that can be implemented within one year are most beneficial to the citizens, employers and providers of Connecticut.

EXECUTIVE SUMMARY

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) (P.L 111-148) into law. This legislation uses a two-pronged approach to comprehensive health reform. First, it aims for universal health insurance coverage coupled with insurance market reforms. Second, it includes a range of pilots and demonstrations designed to test changes to the way care is organized and reimbursed – with the goals of improving health outcomes and controlling costs.

The Health Care Reform Advisory Board has developed recommendations in four areas that will help tailor federal health care reform to the needs of Connecticut. The recommendations and supporting information are summarized below.

Quality and Cost Innovation

In addition to increasing the proportion of persons with health insurance via an individual mandate and an array of insurance reforms, the PPACA was designed to provide states with opportunities to reform the health care delivery and payment systems. This approach takes into account that people not only need insurance cards, they need access to doctors and other medical professionals who can provide them with high quality and affordable care.

The federal reform law includes many voluntary pilots and demonstrations that policymakers, providers, and other stakeholders may use to create innovative, local, collaborative models of delivering better health care at lower costs. Because Connecticut has a lower uninsured rate than much of the country, and because Connecticut is in a region rich with prospects for collaboration, we have the opportunity to succeed at overall system reform. With regards to these opportunities, the Advisory Board recommends that:

- Connecticut encourage policies to enable the formation of Accountable Care Organizations that benefit patients;
- The state pursue all available opportunities that are substantiated as cost effective and that promote access, enhance quality, and generally address reform of the provision of health care services and reform of the delivery or payment system;
- State agencies provide analysis of each opportunity on a real-time basis to the Governor's Health Care Reform Cabinet; and
- The state support the development of a central data repository to collect key data that will monitor and analyze costs associated with healthcare utilization and claims.

Health Insurance Exchanges

One of the means by which federal health care reform aims to increase insurance coverage is through 'the exchange,' a portal that will facilitate the purchase of health insurance for certain individuals and small businesses by offering a choice of plans; providing information to help consumers better understand the options available to them; and establishing common rules regarding the offering and pricing of insurance. The goal of the exchange is to create a more organized and competitive market for health insurance, and many of its responsibilities are set

out in the federal law. There are, however, many decisions left to the discretion of the states. The Advisory Board's exchange-related recommendations are designed to promote:

- Consumer choice;
- Plan competition, innovation, quality and cost-control; and
- Information on provider and health care quality.

The Advisory Board further recommends that Connecticut design an exchange that:

- Focuses on individuals and small groups (e.g. those with 50 or fewer employees);
- Contracts with other state or private entities to handle certain functions, as appropriate;
- Is administered by a quasi-state authority similar in structure to the Massachusetts Connector;
- Has a multi-stakeholder 'Board of Directors' that will bring a balanced and workable approach to carrying out its functions; and
- Works collaboratively with state agencies and within the State's regulatory framework to avoid duplication and to enhance interoperability.

With regards to the exchange, the Advisory Board recommends that Connecticut:

- Quickly develop a plan for implementation of the exchange;
- Actively pursue federal grants for planning and implementation of the exchange; and
- Study the impact of health care reform before layering on any additional requirements.

Patient Care & Healthy Connecticut

While health care reform often focuses attention on the role of governments, employers, insurers, and providers, we know that individuals also have a critical role in achieving population health. Increasingly, individuals, as consumers, are being asked to manage chronic conditions, choose between treatment regimens, and select providers and health plans. In order for reform to be successful, wellness supports must be available to encourage healthy behavior, and Connecticut's primary care system must be ready for an increase in demand for health care services, particularly related to primary care and prevention. Our health care delivery system is not currently well positioned for a shift in how and where patients will be receiving their care. To address these issues, Connecticut should:

- Apply for grants to improve Connecticut's health care and public health care workforce;
- Aggressively seek its share of residency slots for the training of primary care physicians;
- Ensure that state scope of practice laws are appropriate in the context of a reformed health care system, particularly potential licensure for Medical Assistants;
- Enact legislation creating a procedure for administrative review of scope of practice;
- Work with the state's community health centers to maximize receipt of federal money;
- Provide outreach to small businesses to facilitate their receipt of available funding; and
- Seek out funding and pilot opportunities to improve the health status of CT citizens and create a goal to become the healthiest state in nation.

Medical Liability Reform

In Connecticut, physician availability and patient access to care are constrained by the current professional liability environment. Currently, elements of our liability environment are inefficient and unfair to the defendant, and discourage physician practice in the state. Recognizing the relationship among medical liability reform, health care costs, and patient safety, the PPACA includes a demonstration program for states to develop and implement alternative dispute resolution processes while collecting data to contribute to research on the effectiveness of various approaches to medical liability reform. With regard to medical liability reform, the Advisory Board recommends that:

- Connecticut design a demonstration program that utilizes the American Hospital Association's "Framework for Medical Liability Reform" which proposes an administrative compensation system that would be created to compensate patients for injuries that could have been avoided during medical care; and
- Legislation should be enacted to allow for the bifurcation of medical malpractice cases into liability and damages proceedings at the request of either counsel.

Conclusion

After the federal health care reform legislation was signed in March, the Board spent the next two months reviewing the details and creating these practical recommendations. More work will be needed, but if at a minimum these recommendations are implemented, Connecticut will lay the critical foundation of health care reform in our state. At the time of publication, the state is in the process of applying for eight funding opportunities under the PPACA, and Governor Rell has issued Executive Order No. 43, which created the Health Care Reform Cabinet. This Cabinet is charged with developing strategies to apply national health care reform so as to build on Connecticut's existing successful programs and ensure that Connecticut's residents realize the benefits of health care reform.

1. FEDERAL HEALTH CARE REFORM

The PPACA: A two-pronged approach to health care reform

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) (P.L 111-148) into law.¹ This legislation uses a two-pronged approach to comprehensive health reform. First, it aims for universal health insurance coverage coupled with insurance market reforms. Second, it includes a range of pilots and demonstrations designed to test changes to the way care is organized and reimbursed – with the goals of improving health outcomes and controlling costs. This approach takes into account that people not only need insurance cards; they need access to doctors and other medical professionals who can provide them with high quality and affordable care. Health care will not be affordable without significant changes to the delivery system.

PPACA provisions aimed at creating universal coverage starting in 2014:

- Most U.S. citizens and legal residents will be required to have health insurance;
- Medicaid will be expanded to 133% of the federal poverty level;
- Individuals who do not have access to affordable employer coverage will be able to purchase insurance through the exchange (see Section 2 of this report);
- Premium and cost-sharing credits will be available to some people in the exchange to make coverage more affordable;
- Employers will be required to pay penalties for employees who receive tax credits for health insurance through the exchange (with exceptions for small employers);
- Small businesses will be able to purchase coverage through the exchange; and
- New regulations will prevent health insurers from denying coverage to people for reasons of health status, and from charging higher premiums based on health status or gender.

Leading health policy thinkers identifying the importance of health system reform that is both local and collaborative:

- Atul Gawande: *The most interesting, under-discussed, and potentially revolutionary aspect of the law is that it doesn't pretend to have the answers. Instead, through a new Center for Medicare and Medicaid Innovation, it offers to free communities and local health systems from existing payment rules, and let them experiment with ways to deliver better health care at lower costs.*²
- Jim Yong Kim & James N. Weinstein, discussing the need for a new field to tackle the twin problems of providing high-quality health care while lowering costs: *This new field will work with the recognition that truly reforming health care requires more than the efforts of one entity. [...] No single group or entity created the puzzle that is our health care system; it is not reasonable to expect one group to solve it.*³

¹ Health care reform is large and complex, and this report does not attempt to describe the PPACA in its entirety but rather, to describe elements pertaining to the Board's recommendations. Also, in addition to the PPACA, health care reform is enacted through the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) signed into law by the President on March 31 2010. For more information on health care reform, the Kaiser Family Foundation, a non-profit, non-partisan, private operating foundation focusing on the major health care issues facing the U.S. is a good source of information and was used extensively in our analysis. Materials may be found at www.kff.org/healthcare/reform.

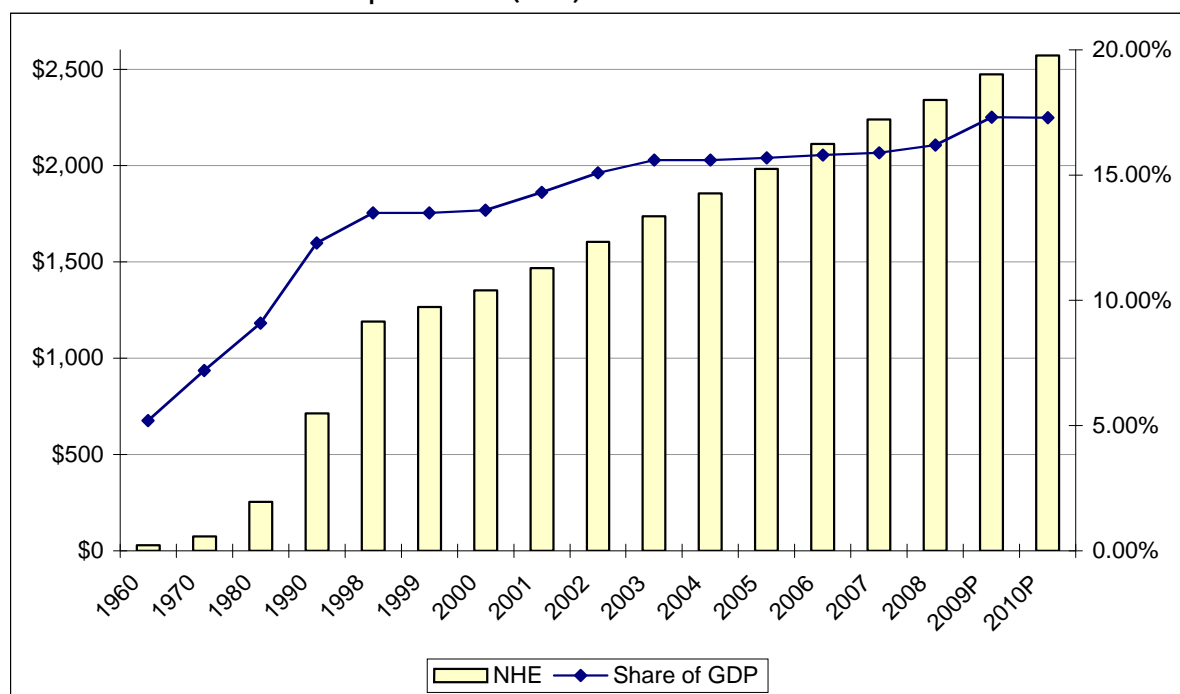
² From a commentary in *The New Yorker*, April 5, 2010. A surgeon and a writer, Atul Gawande is a staff member of Brigham and Women's Hospital, the Dana Farber Cancer Institute, and the *New Yorker* magazine.

³ From an editorial in the *Washington Post*, May 17, 2010. Jim Yong Kim is president of Dartmouth College and James N. Weinstein is president of the Dartmouth-Hitchcock Health Clinic.

Rising Health Expenditures

Steadily increasing health care expenditures (see Figure 1) have led to concerns that the current system is unsustainable and does not deliver equivalent value for the money spent. These issues have led to consensus about the need to “bend the cost curve,” or to achieve long-term savings by modernizing the delivery of medical services. There is a growing body of research investigating the drivers responsible for these costs and debate continues on the extent to which the changes from health care reform have potential to bend the long-term cost curve. Rather than being a sign of wavering commitment to cost savings though, the federal law’s focus on experimentation along so many dimensions, through pilots and demonstrations, indicates a desire to move forward rapidly to address this issue by providing fertile ground for innovation.⁴

FIGURE 1: National Health Expenditures (NHE) 1960-2010: In billions of dollars & as a share of GDP



Sources: Kaiser; <facts.kff.org/upload/jpg/enlarge/3%20National%20Health%20Expenditures%20and%20Their%20Share%20of%20Gross%20Domestic%20Product%201960-2008.jpg>. The White House; <www.whitehouse.gov/administration/eop/cea/chair-remarks-06082009/>. Other federal agencies: <www.cms.gov/NationalHealthExpendData>.

Notes: The Milliman Medical Index, an annual measure of average annual medical spending for a typical American family of four found that in 2010, medical cost for a typical American family were \$18,074 – an increase of 7.8% from 2009. This is the third year in a row where the annual rate of increase has been below 8%; however, the dollar increase of \$1,303 is the highest in the last 10 years and since the inception of this index. Employers and employees both shared the increase in cost this year. <www.milliman.com/expertise/healthcare/products-tools/mmi>.

⁴ The variety of research on this issue includes a report by McKinsey & Company (“Accounting for the cost of U.S. health care: A new look at why Americans spend more.” November 2008. <http://www.mckinsey.com/mgi/publications/us_healthcare/>) that identifies cost-drivers such as demand-related issues; supply-related issues; intermediation-related issues; and social norms and values. The Milliman Medical Index (<<http://www.milliman.com/expertise/healthcare/publications/mmi/pdfs/milliman-medical-index-2010.pdf>>) found that “most of the hospital and physician cost increases identified in this year’s MMI have been driven by average unit cost, not utilization.” For twenty years, the Dartmouth Atlas has documented variations in how medical resources are distributed and used in the United States. <www.dartmouthatlas.org> The Mass. Attorney General’s Office, which was mandated by statute to investigate factors that contribute to growth within the Commonwealth’s health care system, found that contracting practices by health insurance companies and providers have resulted in significant differences in compensation rates among hospitals and physicians that do not appear to be based on the complexity or quality of care provided. <www.mass.gov/Cago/docs/healthcare/Investigation_HCCT&CD.pdf>. The MMI report and an article by David Cutler in Health Affairs (“How Health Care Reform Must Bend The Cost Curve.” June 2010) address opportunities in federal health reform to address some of these issues.

Health Insurance Coverage & the Uninsured in Connecticut

Connecticut's Uninsured Under Health Care Reform

In Connecticut, about 10% of the total State population (335,000 individuals) are uninsured. With federal health care reform in 2014, most of Connecticut's uninsured will become eligible for Medicaid or for subsidized participation in the exchange. (See the left side of Figure 2.)

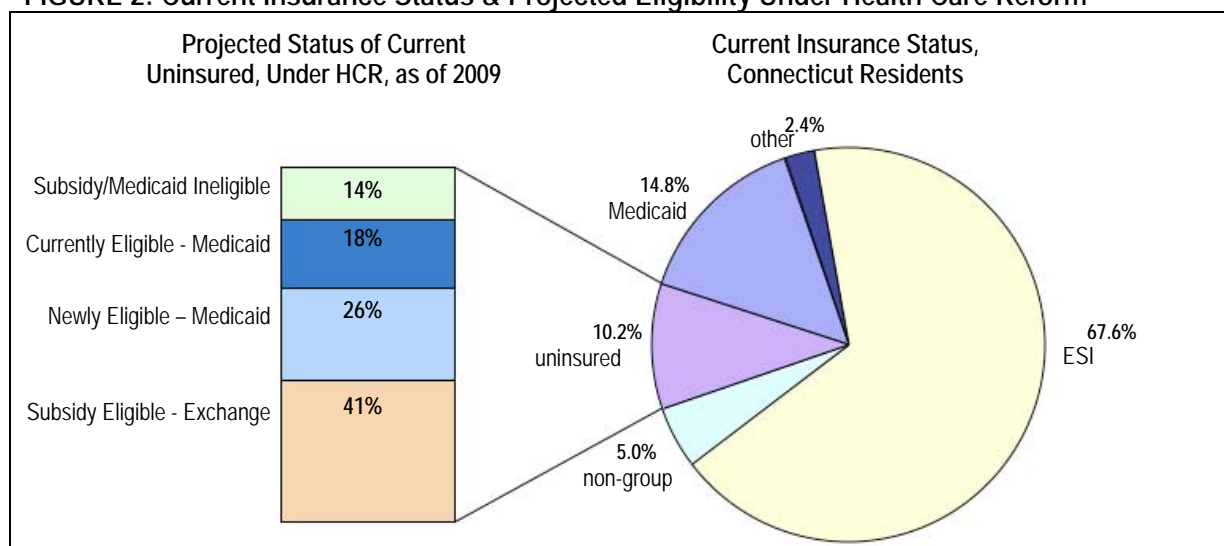
Two-Thirds of Residents Currently Have Employer-Sponsored Insurance (ESI)

At about 60%, Connecticut has a higher rate of ESI coverage than the nation (see right side of Figure 2 & Figure 4B). Most of Connecticut's large employers offer insurance, and about half of firms with less than 50 employees do. But much remains unknown about the response of employers—both large and small—to federal health reform. Towers Watson survey results indicate that most employers plan to or have begun modeling the financial impacts of health reform on their organization. In the meantime, employers are likely to delay non-mandated changes to their benefit plans.⁵ (See Appendices B & C for more detailed data on ESI.)

Medicaid Grows to Cover One-Fifth of the State

Although about 18% of Connecticut's uninsured are currently eligible for Medicaid but not enrolled, it is likely that the individual mandate will result in greater take-up. Together, Medicaid's newly eligible and currently eligible but not enrolled populations will total about 135,000 persons and overall by 2019, the Medicaid population will total one-fifth of the state's insured (see Figure 3, next page). As can be seen in the table and map on the following page, states with high currently uninsured are projected to have far greater Medicaid increases under health care reform than states such as Connecticut with low uninsured.

FIGURE 2: Current Insurance Status & Projected Eligibility Under Health Care Reform



Source: Urban Institute. "How Would States Be Affected By Health Reform?" 2010. (An analysis of the Census Bureau's 2007-2008 Current Population Surveys, simulated as if reforms were implemented in 2009. See Appendix B for data.

Notes: Kaiser estimated about 335,000 uninsured individuals in Connecticut based on the same Census data as used in the chart above. A Families USA study identified about 750,000 individuals who were uninsured at any point during a two-year period (2007 or 2008). (State Fact Sheet. March 2009).

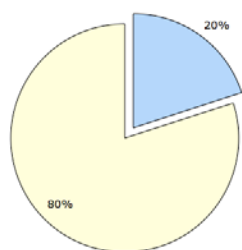
⁵ Towers Watson. "Health Care Reform: Looming fears mask unprecedented employer opportunities to mitigate costs, risks and reset total rewards." May 2010.

Connecticut in a National Context

Opportunities for System Reform

Because Connecticut has a lower uninsured rate than most of the country (Figure 4A), we have the opportunity to turn our attention to system reform aimed at addressing quality and cost. Also, Connecticut is in a region rich with prospects to collaborate in pilots and demonstrations with other eastern states that have similar landscapes of health coverage and the uninsured.

FIGURE 3 & TABLE 1: Estimated Medicaid Enrollment Increases 2014-2019, excluding CHIP

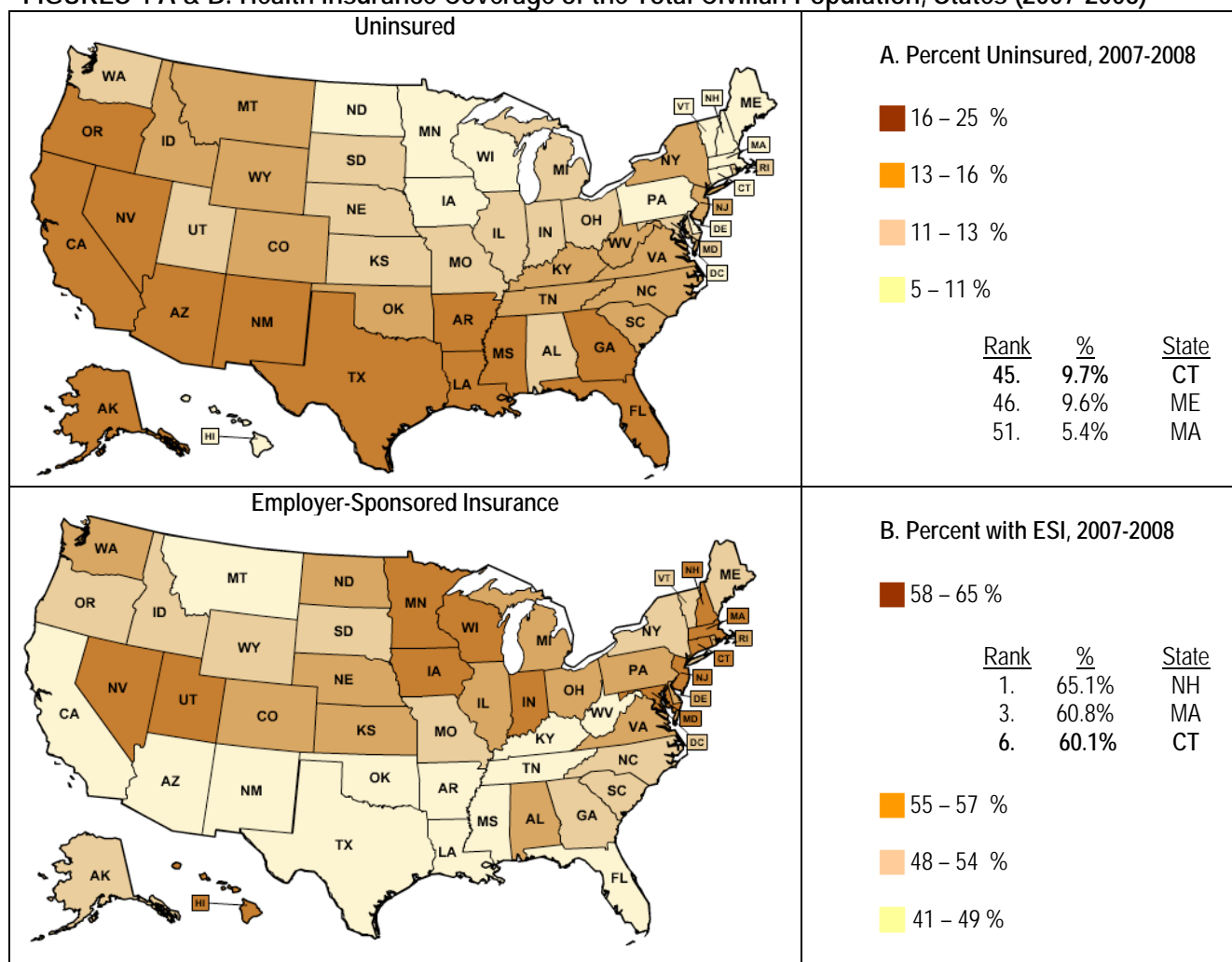


	MA	VT	NY	CT	FL	TX	CA
Persons (thousands)	-6	-7	41	133	1,051	1,904	2,033
% Increase	-1%	-5%	1%	26%	42%	56%	27%

Table Source: UnitedHealth Center for Health Reform. "Coverage for Consumers, Savings for States: Options for Modernizing Medicaid" April 2010. Analytical modeling, pgs 13-14.

Figure Source: Kaiser Commission on Medicaid and the Uninsured. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL." May 2010. Pages: 10-11. The Kaiser report estimated a range of 114,000-155,000 CT residents eligible for Medicaid, with 76,000-114,000 of those being previously uninsured and newly enrolled.

FIGURES 4 A & B: Health Insurance Coverage of the Total Civilian Population, States (2007-2008)



Source: State Health Facts, a project of the Kaiser Family Foundation. <statehealthfacts.org>

Linking Service Delivery Reform and Payment Reform (AKA, Bending The Cost Curve)

The PPACA provides an array of tools for state government and providers to implement voluntary pilots and demonstrations that could spur significant delivery system innovation. The reform laws also establish the Center for Medicare and Medicaid Innovation (CMI) within the federal Centers for Medicare and Medicaid Services (CMS) to test payment and delivery models that improve quality and slow cost growth. The CMI proposed 18 payment of delivery models for consideration (see Appendix E).

The following are among the many approaches envisioned under health care reform:⁶

Bundling

Paying a single fee for an entire episode of treatment (e.g. for hospital readmissions or for care for chronic conditions).

Accountable Care Organizations (ACOs)

Provider-led organizations whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population. ACOs could, for example, accept a single capitation payment and would be responsible for providing all services to their enrollees. Multiple forms of ACOs are possible, including large integrated delivery systems, physician-hospital organizations, multi-specialty practice groups with or without hospital ownership, independent practice associations, and virtual independent networks of physician practices.

Value-Based Purchasing

Pay-for-performance linking existing measures of inpatient quality to payments, and expanding pay-for-performance to outpatient care, physician services, home health care, and skilled nursing facilities.

Care Coordination Including Patient Centered Medical Homes

An approach to making comprehensive primary care available through a physician-led team of individuals who collectively take responsibility for providing ongoing, coordinated, and integrated care to patients. The medical home model puts emphasis on medical management rewarding quality, patient-centered care.

The key to the success of these models is establishing a synergistic approach to their implementation. For example, the medical home model alone is no cure-all without relationships between providers because primary care providers have little direct leverage over other providers in the care continuum. Similarly, regardless of organizational structure, ACOs will not succeed without a strong foundation of high-performance primary care.

⁶ This list was gathered mainly from two sources: a NEJM article, "Primary Care and Accountable Care – Two Essential Elements of Delivery-System Reform." From October, 2009; and David Cutler's Health Affairs article cited previously. Although many evaluations of these models are just beginning (or being planned), the Patient-Centered Primary Care Collaborative recently published a review of recent PCMH evaluations ("The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies." August 2009. <www.pcpc.net>).

RECOMMENDATIONS

Service Delivery and Payment Reform

1. Connecticut should encourage policies to enable the formation of Accountable Care Organizations in Connecticut linking payment reform to these new care delivery models for the benefit of patients.
2. The State should pursue all available opportunities presented by the passage of health care reform that are substantiated as cost effective and that promote access, enhance quality, and generally address reform of the provision of health care services and reform of the delivery or payment system. State agencies should provide analysis of each opportunity on a real-time basis to the Governor's Health Care Reform Cabinet to promote transparency. The opportunities include but are not limited to:
 - 'Medicaid Demonstration project to evaluate integrated care around a hospitalization' (P.L. 111-148 section 2704);
 - 'Medicaid global payment system demonstration project' (P.L. 111-148 section 2705);
 - Medicare/Medicaid patient-centered medical home demonstration project.
3. Support the development of a central data repository to collect key data that will monitor and analyze costs associated with healthcare utilization and claims to identify the drivers of cost.

2. HEALTH INSURANCE EXCHANGE(S)

Role of the Exchanges in Federal Health Reform

The goal of the exchange is to create a more organized and competitive market for health insurance. As in the image below of the Massachusetts Connector, an exchange is a website to purchase health insurance. An exchange offers a choice of plans; provides information to help consumers better understand the options available to them; and establishes common rules regarding the offering and pricing of insurance.⁷

The exchange is a key element in providing coverage to certain segments of the uninsured population; more than 40% of Connecticut's currently uninsured will be eligible for some subsidies in the exchange,⁸ and many employees of small businesses will benefit from its availability. Although most large employers offer ESI and many employers with between 10-50 employees do as well, only 38% of employers with less than 5 employees offer ESI (Appendix C). Connecticut's exchange will particularly benefit those populations. The exchange will serve two groups: individuals and small businesses (they may be combined in one exchange).

- **American Health Benefit Exchange:** To offer health plans to all individuals not covered by ESI, beginning in 2014 (including persons with incomes 133-400% FPL who are eligible for premium and cost-sharing subsidies).
- **Small Business Health Options Program (SHOP):** To offer plans to employers (2014-2016, the state may offer SHOP to businesses with up to just 50 employees; in 2016 the state must open eligibility to employers with up to 100 employees; after 2017 state may expand to businesses with more than 100 employees).

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⁷ From the Kaiser summary of federal health reform (see note 1). <<http://www.kff.org/healthreform/upload/8061.pdf>>

⁸ Urban Institute. "How Would States Be Affected By Health Reform?" 2010.

State Exchange-Related Responsibilities

Each state is responsible for creating an exchange by January 1, 2014; if a state has not taken necessary implementation actions by January 1, 2013, the federal government will establish an exchange for them. Federal funding to establish the exchange will be distributed within one year of enactment of the PPACA and will be available through January 1, 2015. After that point, each state exchange must be self-sustaining.

The following is an overview of the responsibilities of an exchange. There are other state options regarding the design and operation of the exchange, including coordination with the state's Medicaid program. The federal government will issue regulations setting standards for meeting these and other requirements of the exchange. (See Appendix G for additional information regarding the options and responsibilities of each exchange.)

- Certify qualified health plans;
- Offer a toll-free telephone hotline for customer service and enrollment assistance;
- Create a website with standardized comparative information;
- Assign a rating to each health plan;
- Use a standardized format for presenting benefit options;
- Inform individuals of eligibility requirements for Medicaid/CHIP and, if eligible, enroll individuals;
- Provide a calculator to determine cost of coverage after tax credits;
- Certify exemptions from the individual requirement;
- Notify employers when their employees cease coverage;
- Establish the Navigator program (grants to entities for public education, enrollment information & facilitation, and referrals for complaints);
- Consult with stakeholders including consumers, businesses, insurers, Medicaid, and advocates; and
- Request justification regarding premium increases.

In addition to these statutory responsibilities, the exchange will also be responsible for various other functions to be carried out in accordance with federal guidelines. These responsibilities are likely to include creating a uniform enrollment form; providing enrollee satisfaction information; quality rating of plans; determining enrollment periods; coordinating with the federal government regarding multi-state and nonprofit plans; sharing information as needed with the IRS; and ensuring compliance with federal laws, regulations, and reporting requirements.

To carry out its functions, the exchange will require a range of staff expertise and/or outside services.

RECOMMENDATIONS

Health Insurance Exchange(s)

4. The exchange should offer one-stop shopping that promotes consumer choice through direct access to or linkage with:
 - Clear information comparing plans and offering plan specifics;
 - Real-time decision support tools;
 - Eligibility determinations for public subsidies, Medicaid/HUSKY A, SCHIP/HUSKY B, Charter Oak Health Plan, or other programs;
 - Estimations of premiums once subsidies are applied;
 - Easy enrollment in or purchase of coverage.

5. The exchange should encourage plan competition, innovation, quality and cost control by:
 - Promoting a variety of distribution methods, as provided in federal law, and allowing for broad plan participation in the exchange;
 - Promoting the sale of coverage inside and outside of the exchange by supplementing the current market, thus enhancing consumer options;
 - Implementing federal regulations related to quality improvement, adequate provider networks, and costs for plans offered throughout the exchange in a manner that improves quality and controls costs, but does not impose requirements that are not proven or tested methods of achieving these goals.

6. The exchange shall develop a plan to be submitted to the Governor and General Assembly that will consider ways to provide objective, independent information on provider and health care quality, using accredited methods.

7. The exchange should focus efforts on individuals and small groups (e.g., those with 50 or fewer employees, unless otherwise prohibited by federal law) because individuals and small employers with less than 50 employees are those most in need of additional access to insurance.
 - Focus on small employers with 50 or fewer employees in the exchange until the deadline of moving to 100 or fewer employees in 2016;
 - Any decision to include businesses with over 50 employees before 2016 or businesses with over 100 employees after 2017 should be made by the legislature and not delegated to the exchange and should only occur following a full assessment of the impact of this and other market changes under the federal health care reform law;
 - Assure plan solvency and a level playing field by ensuring that every plan in the exchange is regulated equally, subject to the same statutory and regulatory standards.

8. The State shall study the impact of federal health care reforms on the State, its residents and stakeholders before layering on any additional requirements because:
 - Many of the new requirements do not exist in the State today, the details of which are still to be promulgated by HHS, and their effects will need to be measured; and
 - There is a need to balance coverage with premium affordability and be cognizant that the state has fiscal liability for additional insurance mandated above the federal minimal essential benefits.
 - The director of the exchange should report annually to the Governor and the General Assembly regarding the effects of reform on, including but not limited to, small employers, other group markets, individual policy holders, rates of uninsurance and penalty enforcement and results; and the effect on the delivery system as a whole.

9. The exchange should be allowed, as provided in federal law, to contract with other State and private entities to handle exchange functions, as appropriate, including but not limited to:
 - “Contract” with DSS for eligibility determination services for DSS coverage programs including premium subsidy and cost sharing tax credits for individuals referred by or through the exchange, with the exchange serving in a facilitation role;
 - Subcontract with entities, as well as potentially with one or more exchanges currently operated for small employers to address this market.

10. The State should be actively pursuing federal grants for the planning, implementation, and establishment of the exchange.

11. The exchange shall have a multi-stakeholder ‘Board of Directors’ providing it with the range of expertise and points of view that will bring a balanced and workable approach to carrying out its functions. The membership of the board should include:
 - The Secretary of the Office of Policy and Management (ex-officio), who will serve as chair;
 - An actuary, a health plan benefit specialist, and a health care economist;
 - Representatives from a small business, a large business, and labor;
 - Representatives of the insurance industry, providers and consumers; and
 - The Commissioners of Social Services, Public Health and Insurance, and the State Comptroller, or their designees (voting, ex-officio).
 - The non-ex-officio board members shall be appointed for four year staggered terms, a majority of whom shall be appointed by the Governor.

12. It is recommended that the Governor’s Health Care Reform Cabinet develop a plan for implementation of the exchange and submit draft proposed legislation for the establishment of the quasi-authority to the Governor by 09-01-10, with the goal being to enact legislation no later than 03-31-10.

13. The exchange(s) shall be administered by a quasi-state authority, similar in structure to the Massachusetts Connector. The duties of the authority would be to carry out the functions of the exchange identified in federal reform legislation. While the exchange authority would need to be granted some flexibility in administering these functions, broader policy issues affecting the insurance market, including regulation of the market, should remain with the Governor, the General Assembly, and the Department of Insurance.

14. To the extent possible, the exchange shall work collaboratively with state agencies and within the State's regulatory framework in order to avoid duplication and to enhance interoperability.

3. PATIENT CARE & HEALTHY CONNECTICUT

The importance of individual behavior

While health care reform often focuses attention on the role of governments, employers, insurers, and providers, the data on illness triggers shows that individuals also have a critical role in achieving the goal of a healthy population. Individual behavior is sometimes outside the influence of social forces such as government and insurers. Yet increasingly, individuals, as consumers, are being asked to manage chronic conditions, choose between treatment regimens, and select providers and health plans.

Research shows that individual participation can improve adherence to treatment, increase use of screening, increase patient satisfaction, and result in better outcomes and lower costs.⁹ However, a recent survey of consumers found a fundamental disconnect between the central tenets of evidence-based health care and the knowledge, values, and beliefs held by many consumers.¹⁰ Patient trust in the system is a key factor in implementation of health system change, particularly as patient involvement is important in making the medical home model a success.

Often, employers provide wellness initiatives to their employees because employers have a stake in healthy employees and health care cost savings, and thus an incentive to foster wellness by helping employees prevent diseases and control the diseases they have.¹¹ Federal health care reform includes some grant funding for small businesses to provide health insurance to their employees, and (separately) to develop wellness programs.

Healthy Connecticut

Preventative services and wellness initiatives are an important aspect of healthy communities. Using early intervention to address illness triggers like obesity and smoking could improve population health and reduce demand for some health care services. Although Connecticut is ranked well compared to many states (see Figure 5), nearly half of Connecticut's residents are overweight/obese and 16% still smoke. This demonstrates the important role of individual behavior and another critical component to the success of health care reform.

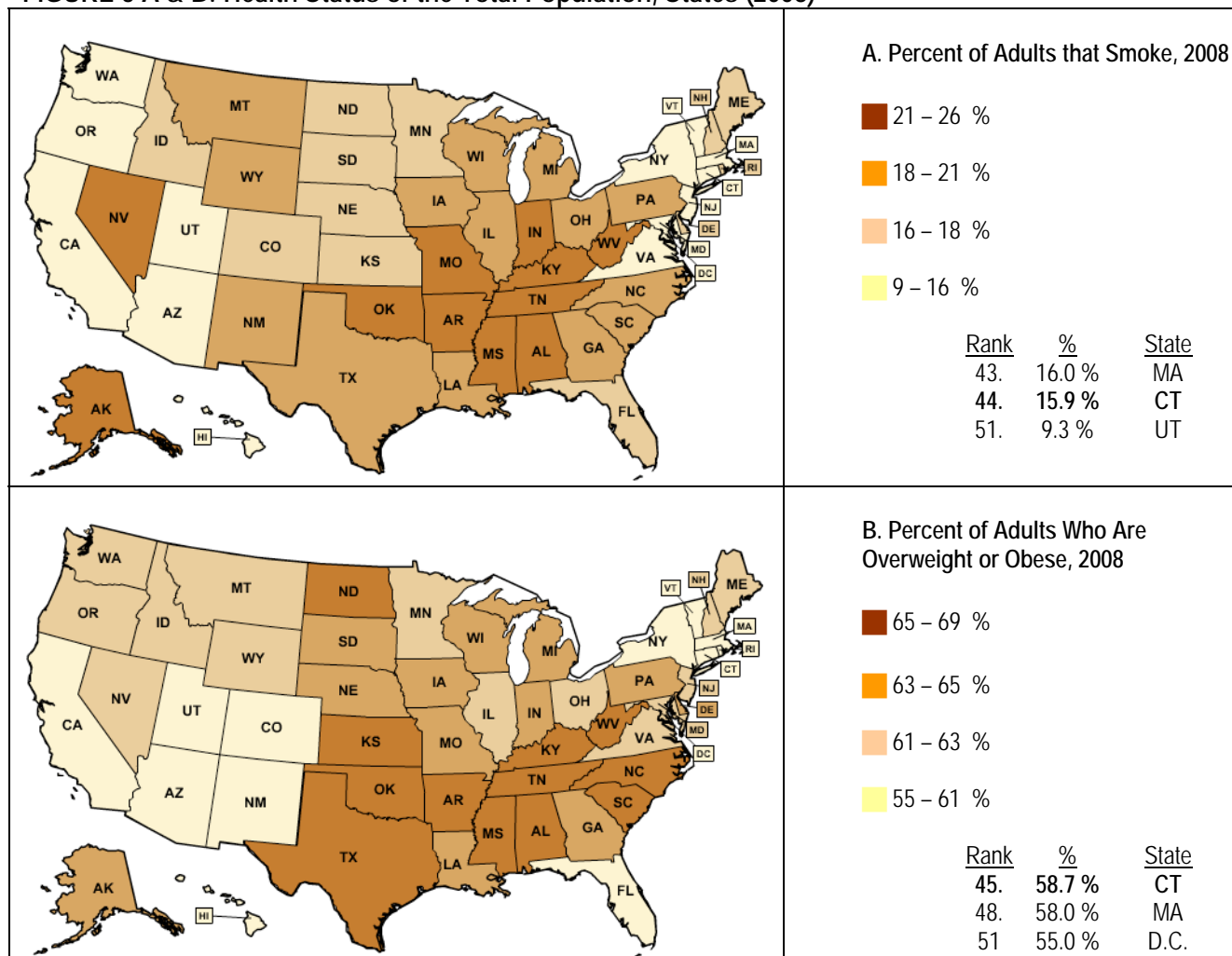
A keystone of successful health care reform in Connecticut will be to continue our emphasis on health promotion and disease prevention within the reformed health care system. Only by addressing the preventable conditions that lead to poor health and high health care costs can we achieve lasting solutions to the problems that ail our health system; and only by ensuring there is a primary care workforce prepared to assist individual patients with their health goals can we claim to have been successful by increasing access to health insurance.

⁹ Carmen, Kristen, et al. "Evidence That Consumers Are Skeptical About Evidence-Based Health Care." Health Affairs. July 2010.

¹⁰ A study that identified this disconnect ("Evidence That Consumers Are Skeptical About Evidence-Based Health Care," see above) noted that for health care experts, variation—in quality among health care providers, the evidence base regarding therapies, and the effectiveness and cost-effectiveness of treatment options—is a well-established fact of the health care system, documented extensively in the published literature and well understood after years of careful study. Yet such concepts are unfamiliar to many Americans and may even seem threatening, to the extent that they raise unwelcome questions about the quality of medical care that people receive."

¹¹ Galvin, Robert S. and Delbanco, Suzanne. "Between A Rock and A Hard Place: Understanding the Employer Mind-Set." Health Affairs. November/December 2006. Galvin, Robert S. "Still in the Game – Harnessing Employer Inventiveness in U.S. Health Care Reform." NEJM. October 2008.

FIGURE 5 A & B: Health Status of the Total Population, States (2008)



Source: State Health Facts, a project of the Kaiser Family Foundation. <statehealthfacts.org>

Primary care is critical to the success of federal health care reform.

It is well-known that U.S. states with higher ratios of primary care physicians to population have better health outcomes under a range of measures.¹² Yet it is also known that an increase in the number of persons with insurance will likely strain the primary care system. Massachusetts, the state with one of the highest number of primary care physicians per 100,000 population at the time they enacted reform (they are currently second, after Washington, D.C., and Connecticut is ranked sixth) has found the availability of primary care physicians for newly insured residents to be of serious concern.¹³ In 2009, one in five Mass. adults reported that they had not received needed health care, and one in seven reported an emergency department visit for a nonemergency condition.¹⁴

¹² Some of this research is summarized in a University of Connecticut Center for Public Health and Health Policy study, "Assessment of Primary Care Capacity in Connecticut," from December 2008.

¹³ Massachusetts Medical Society. "2009 Physician Workforce Study." September, 2009. <www.massmed.org> The study found that the primary care specialties of family medicine and internal medicine are in short supply for the fourth consecutive year, and the percentage of primary care practices closed to new patients is the highest it's ever been as recorded by the Medical Society.

¹⁴ Long, S. & Stockley, K. "Sustaining Health Care Reform in a Recession: An Update on Massachusetts as of Fall 2009." June 2010.

Although Connecticut is poised better than many states, there are still many strains on the primary care system. In a survey, roughly 40% of physicians in primary care specialties (internal medicine and family medicine) reported decreases in the number of physicians in these specialty areas.¹⁵ Difficulty in recruitment and retention of physicians were particularly acute in certain geographic areas, adding stress to those regions' health care systems; in Litchfield, New London, and Windham counties, more than 90% of respondents indicated that recruiting physicians was either very difficult or somewhat difficult.

Some licensed primary care physicians likely choose not to practice due to specific aspects of the current practice environment such as documentation requirements, insurance issues, rushed patient visits, and medical liability concerns."¹⁶ In a recent study, while generally satisfied with their careers in medicine, physicians demonstrated marked negativity toward practicing medicine in Connecticut. At a time when the medical training system relies heavily on existing physicians to train their younger colleagues in medical school, residency and fellowship programs, physicians were not strongly inclined to recommend a Connecticut practice to young physicians.¹⁷

The role of primary care and prevention services is highlighted in federal reform since a substantial cost savings will be realized if we focus on achieving a healthier population. The existing health care delivery system in Connecticut is not well positioned for this shift in how and where patients will be receiving their care. The physicians and other medical professionals will need to be trained differently in order to be responsive to the system and payment reforms of the future.

Existing entities are addressing health care information technology

The Federal Administration and the U.S. Congress have put health information technology on the forefront in the health care reform debate, by providing funding for states through the Health Information Technology for Economic and Clinical Health (HITECH) Act within the American Recovery and Reinvestment Act (ARRA). The Connecticut Department of Public Health is the state's lead health information exchange organization and coordinates a 12-member Health Information Technology and Exchange Advisory Committee (HITEAC) working on this issue. The Health Care Reform Advisory Board determined that any efforts in this area would be duplicative; therefore, the Board defers to the work of the HITEAC.

¹⁵ Connecticut State Medical Society. "Connecticut Physician Workforce Survey 2008: Final Report on Physician Perceptions and Potential Impact on Access to Medical Care." 2008.

¹⁶ University of Connecticut Center for Public Health and Health Policy. "Assessment of Primary Care Capacity in Connecticut." December 2008. Page 9.

¹⁷ Connecticut State Medical Society. "Connecticut Physician Workforce Survey 2008: Final Report on Physician Perceptions and Potential Impact on Access to Medical Care." 2008.

RECOMMENDATIONS

Health and Wellness

15. In order to improve and strengthen Connecticut's health care and public health care workforce, Connecticut should apply for Health Workforce Development Planning & Implementation Grants (P.L. 111-148 section 5102), including but not limited to:
 - *'Health Workforce Development Planning Grant'* to analyze health care labor markets; identify current and projected needs; identify short and long-term workforce development strategies; identify existing Federal, State and private resources for health workforce recruitment, education, training and retention.
 - *'Health Workforce Development Implementation Grant'* to encourage regional partnerships and promote innovative workforce pathway activities. This grant will allow Connecticut to address the workforce needs of a reorganized health care delivery systems (i.e. accountable care organizations, medical homes) and address the need to have health care professionals function in new/changing roles.

16. Connecticut should aggressively seek its share of residency slots for the training of primary care physicians.
 - Work with the Congressional Delegation and also be involved during the rulemaking process regarding *'Distribution of Medicare graduate medical education (GME) positions'* (P.L. 111-148 section 5503), to ensure that Connecticut is able to obtain additional residency slots, based on analysis of available data.
 - Develop linkages between teaching hospitals and qualified hospital and physician practices in medically underserved or rural settings.
 - Address the training needs of primary care in health care reform, broadly to include internal medicine, family practice, pediatrics and obstetrics and gynecology.

17. Connecticut must ensure that the state scope of practice laws are appropriate in the context of a reformed health care system. As a general principle, changes to these laws should take place in a transparent, coherent manner that takes into account the need for providers to maximize the use of their training.
 - DPH shall convene a group of representative of relevant stakeholders that will evaluate the necessary components to creating a new licensure category for medical assistants; and
 - DPH will submit a proposal for the 2011 legislative session.

18. Connecticut should enact legislation creating a procedure for administrative review led by DPH with stakeholder participation for proposed changes to scope of practice laws prior to being raised in the legislature.
 - This process should include an evaluation of proposed changes to or creation of a licensure category based on the “Guideline Questions for Determining Scope of Practice” included in the 2010 Legislative Program Review & Investigations Committee Report entitled Scope of Practice Determination for Health Care Professions (available at: http://www.cga.ct.gov/pri/2009_PDHCP.asp).
 - The Department should identify and pursue grants/demonstrations available through the PPACA that would assist with funding to implement this process.

19. DPH should work with the state’s community health centers and school-based health centers to maximize the receipt of federal money for the purposes of: maintaining and expanding the number of such clinics; maintaining and expanding the number of such clinics that possess FQHC status; ensuring that these sites provide safety net coverage for the entire state population; and utilizing new methods of integrated care coordination.

20. The state should provide outreach to and work with small businesses in order to facilitate their receipt of available funding in health care reform for grant opportunities including:
 - *‘Grants For Small Businesses To Provide Comprehensive Workplace Wellness Programs’ (P.L. 111-148 section 10408)*
 - *‘Credit For Employee Health Insurance Expenses of Small Businesses’ (P.L. 111-148 section 1421)*

21. DPH should seek out funding and pilot opportunities to improve the health status of CT citizens and create a goal to become the healthiest state in nation.

4. MEDICAL LIABILITY REFORM

Growing consensus about the need for medical liability reform

In Connecticut, patient access to care is constrained by the current professional liability environment. In a 2008 survey, 33% of physicians reported that they had reduced the number of high risk patients they saw, and 38% had reduced the number of high risk procedures they performed (substantial variability by specialty was observed).¹⁸

Nationally, there is growing consensus about medical liability reform. An Agency for Healthcare Research and Quality (AHRQ) report examined what is known about the impact of different approaches to reform on health care costs and patient safety and concluded that now is an opportune time to experiment with alternative approaches to the medical liability system.¹⁹

A September 2009 Fact Sheet issued by the White House²⁰ identified the following facts that underscore the importance of such reform:

- According to the IOM report *To Err is Human*, between 44,000 and 98,000 patients die each year from medical errors.²¹
- Patients who are seriously harmed from medical errors often wait too long for compensation.²²
- Many experts believe fear of liability is a substantial barrier to the development of transparent and effective patient safety initiatives in hospitals and other settings.²³
- Many doctors believe that medical liability concerns lead to "defensive medicine," which in turn may contribute to higher costs.²⁴
- Many physicians continue to struggle to pay their medical malpractice premiums, which vary tremendously by specialty and by state.²⁵
- The cost of insurance continues to be one of the highest practice expenses for some specialties.²⁶
- Fears of medical malpractice claims may lead to altered practices, restricted emergency coverage, and limited or discontinued high-risk procedures.²⁷
- The evidence regarding the impact of prior efforts to reduce the occurrence of lawsuits or the unintended consequences of lawsuits (e.g., physician shortages in selected areas) is equivocal.²⁸

¹⁸ Connecticut State Medical Society. "Connecticut Physician Workforce Survey 2008: Final Report on Physician Perceptions and Potential Impact on Access to Medical Care. 2008. Also, the Connecticut Insurance Department releases the 'Connecticut Medical Malpractice Annual Report,' summarizing the medical malpractice liability closed claim data received by the Department. The 2010 edition of this report can be found at: < <http://www.ct.gov/cid/lib/cid/MedicalMalpractice2010Report.pdf>>.

¹⁹ "Review of Reforms to Our Medical Liability System." December 31, 2009. <www.ahrq.gov/qual/liability/reforms.htm>

²⁰ The White House. "FACT SHEET: Patient Safety and Medical Liability Reform Demonstration." September 17, 2009. <www.whitehouse.gov>

²¹ Kohn LT, Corrigan JM, Donaldson MS, eds. "To err is human: building a safer health system." 2000.

²² JCAHCO. "Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury." 2005.

²³ Studdert, DM, Mello, MM, Brennan TA. "Medical Malpractice." *NEJM* 350: January 15, 2004.

²⁴ Studdert DM, Mello MM, Sage WM et al. "Defensive Medicine among High-risk Specialist Physicians in a Volatile Malpractice Environment." *JAMA* 2005; 293(21).

²⁵ American Medical News. "Medical Liability Monitor 2008 Rate Survey." January 5, 2009. <www.americanmednews.com>

²⁶ Terry K. "Malpractice premiums: Dropping but still high. *Medical Economics*. August 1, 2008. <medicaleconomics.modernmedicine.com>

²⁷ See Studdert DM, "Defensive Medicine", above.

²⁸ Kessler, DP, Sage, WM, Becker DJ. "Impact of malpractice reforms on the supply of physician services." *JAMA* 2005; 293: 2618-2625. See also Budetti PP. "Tort Reform and the Patient Safety Movement: Seeking Common Ground." *JAMA* 2005; 293(21) at 2661.

Medical liability reform in health care reform.

Given the common acknowledgement of the issues surrounding medical liability, the lack of medical liability reform provisions in the new federal legislation was at first disappointing to many. However, recognizing the current lack of agreement regarding solutions to the issue, and recognizing the legal hurdle of federalism, Congress included a demonstration grant program (Sec. 10607) which will allow states to experiment with versions of medical liability reform that address the decision-making and compensation system itself, beyond the contentious issue of caps on non-economic damage awards.

The “State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation” grant provides funding for the development and implementation of alternative dispute resolution processes along with the collection and analysis of data. This demonstration program offers a way to test change in Connecticut and contribute to research on the effectiveness of various approaches to medical liability reform.

The benefits of a demonstration include:

- Connecticut could access funds to plan the demonstration program with relevant stakeholders before applying for funds to implement it;
- A demonstration would be less contentious than legislative change at this time, because it would not limit or curtail a patient’s existing legal rights including the ability to file a claim in the legal system; and
- Such a demonstration can act as a first step by producing evidence regarding the benefits of greater medical liability reform.

Administrative Compensation System

The American Hospital Association’s (AHA’s) “Framework for Medical Liability Reform” (see Appendix H) proposes an administrative compensation system that would be created to compensate patients for injuries that could have been avoided during medical care. Decisions under this structure are often made using evidence-based clinical guidelines and schedules for compensation amounts.

The AHA framework is consistent with an approach put forward by Michelle Mello in a 2009 article, which stated that administrative or specialized tribunals “would address several fundamental problems with the current system, in which juries make decisions with scant guidance on complex scientific issues and what constitutes reasonable damage awards.”²⁹ The AHA framework also incorporates other approaches from the same article such as “insulating physicians from liability if they adhere to evidence-based medical practices.” According to Mello and her co-author, the following are likely or potential benefits of an administrative system:

- Improve predictability of litigation outcomes through greater use of decision guidelines and expertise;
- Replace “battles of the experts” with use of neutral experts or expert adjudicators;
- Promote physicians’ uptake of comparative-effectiveness research and adherence to practice guidelines;

²⁹ Mello MM, Brennan TA. The role of medical liability reform in federal health reform. *N Engl J Med* 2009;361(1):1-3.

- Reduce length and adversarial nature of litigation processes; and
- Reduce costs if guidelines for damage awards were adopted.

The AHA framework includes the following main components (see Appendix H):

- Claims for injury during medical care would be handled through an administrative process (intentional injuries and criminal acts would remain in the courts);
- Compensation would be provided for injuries that could have been avoided and that meet a minimum threshold of harm;
- Patients would submit claims to a local panel that would make decisions using explicit nationally established decision guidelines and schedules; and
- Patients who question the local panel's decision would bring their claim to other sources that might include an expert panel, administrative law judge, or the court system.

Bifurcation of medical liability cases into liability and damages proceedings

The trial of virtually all medical liability lawsuits is divided into two major phases: liability and damages. Liability issues include whether the physician deviated from the standard of care and caused injury to the patient. Damages issues include evidence of the nature and extent of the injury, and the economic, physical, and emotional impact on the patient and family.

Under current law, liability and damages are automatically considered together, with bifurcation at the discretion of the judge.³⁰ However, motions for bifurcation on the part of defendants are usually denied; the general reason cited is that liability and damage are “inextricably intertwined.” Effectively, under current law, there is a presumption against bifurcation – this system implicitly implies the assumption of wrongdoing.

There are two concerns with trying liability and damages together in a single proceeding. First is the danger that damages evidence will overwhelm the jury and that sympathy for a person with an illness or disability will cause the jury to find for the plaintiff without regard to the fault of the defendant. This danger is especially acute in medical liability cases in which a plaintiff may have experienced a serious complication but where the evidence of fault is weak. This creates an effective prejudice against many defendants. Second, the joint trial of liability and damages creates efficiency problems in the system. Weeks may be spent trying damages evidence even when no liability has yet been established. In such situations, it would be far more efficient to try damages only after liability is found.

³⁰ Section 52-205 of the General Statutes and Rule 15-2 of the Connecticut Rules of Civil Procedure authorizes a trial judge to bifurcate liability and damages.

RECOMMENDATIONS
Medical Liability Reform

22. Connecticut should apply for funding under the “*State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation*” (P.L. 111-148 section 10607) and should design a demonstration program that includes the following components:
- Connecticut’s demonstration program should utilize the American Hospital Association’s “Framework for Medical Liability Reform” which proposes an administrative compensation system that would be created to compensate patients for injuries that could have been avoided during medical care.
 - Participants in the demonstration should be required to provide relevant medical malpractice data to the Connecticut Insurance Department.
23. Legislation should be enacted to allow for the bifurcation of medical malpractice cases into liability and damages proceedings at the request of either counsel.

5. COST ANALYSIS, FUNDING SOURCES, AND IMPACT ON CONNECTICUT'S ECONOMY

In general, estimating the cost and impact of health care reform to states and businesses is extremely difficult. Making this point, the CMS Chief Actuary stated [in a letter dated April 22, 2010]³¹:

The actual future impacts of the PPACA on health expenditures, insured status, individual decisions, and employer behavior are very uncertain. The legislation would result in numerous changes in the way that health care insurance is provided and paid for in the U.S., and the scope and magnitude of these changes are such that few precedents exist for use in estimation.

After passage of the PPACA, Connecticut's Department of Economic and Community Development analyzed the cost of health care reform to businesses and the Connecticut economy. Their analyses confirmed that often, the detailed data needed to accurately estimate costs – whether by firm size, type of firm, premiums and administrative costs, etc. -- was not available in the format needed. It has also become apparent that assessing the costs associated with health care reform are difficult because provider, business, insurance, and government reactions to the new legislation are not always clear at this early stage without full implementation, particularly of the market reforms. Three months into federal health care reform, much remains unknown.

Executive Order #30 requires that the Connecticut Health Care Reform Advisory Board analyze the cost of its recommendations and identify all funding sources to be used to finance and administer these recommendations. To some extent, as with health care reform, estimating the related costs of the Board's recommendations is a moving target. Yet the Board has maintained among its main principles another requirement of Executive Order #30: "emphasize cost containment and maximizing federal funds." The Board has at all times aimed to present a set of recommendations that are low-cost in the near term but that will also have a controlling effect on costs long-term. In many cases, the Board has proposed recommendations that are intended to mitigate the cost impact of health care reform on Connecticut while ensuring that our citizens benefit from increased access to health care and health insurance.

³¹ Centers for Medicare and Medicaid Services. Office of the Actuary. "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended." April 22, 2010. Page 4. <https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf>