HealthFirst Connecticut Authority

Co-Chairs
Margaret Flinter
Tom Swan

State-Wide Primary Care Access Authority and HealthFirst Connecticut Authority,
Joint Meeting
May 14th, 2008, 9:00 AM in Room 1C of the LOB

Meeting Summary

Present were: Margaret Flinter, Tom Swan, Sharon Langer, Angelo Carabba, Sandra Carbonari, Lynn Price, Sharon Langer, Sal Luciano, Teresa Younger, Evelyn Barnum, Commissioner Thomas Sullivan, Sandra Carbonari, Franklin Sykes and Brian Grissler.

Also present were: President Pro Tempore Donald Williams, Leo Canty, David Krause representing Comptroller Nancy Wyman, Paul Grady representing Mike Critelli, Randy Bovbjerg, Barbara Ormond, and Dr. Mitch Katz

Absent were: Commissioner Robert Galvin, Commissioner Michael P. Starkowski, Dr. Daren Anderson, JoAnn Eaccarino, Dr. Robert McLean, Fernando Betancourt, David Benfer, Lt. Governor Michael Fedele, Mickey Herbert, Lenny Winkler, and Kevin Lembo

Margaret Flinter welcomed both Authorities to the meeting. Margaret Flinter read the charge of the two Authorities.

Tom Swan asked for approval of the April 3rd Primary Care Access Authority meeting minutes.

The meeting minutes were approved.

Tom Swan offered an update of the Quality, Access and Safety Workgroup which dealt with racial disparities in healthcare. The Cost, Cost Containment and Finance workgroup dealt with healthcare data, what data is available and how technology may be able to help improve coordination of care.

Randy Bovbjerg offered a presentation on the employee retirement income security act (ERISA). ERISA is a federal statute that regulates employer and union health benefits plans, which are a mainstay of coverage, and blocks state regulation, even if it is not in direct conflict with any federal rules. Therefore, states must act carefully with any rule that affects employee benefit plans.

ERISA supersedes any and all state laws that relate to any employee benefit plan.

There are exceptions to ERISA. States may continue to regulate insurance, banking and securities. This is called the “savings clause.” A state may affect an employee benefit plan by regulating insurance.

States may not deem private employer or union plans to be "insurance." This is known as the "deemer," clause. States thus cannot regulate self-insurance.

It is permissible to tax fully insured health plans, health care providers, or employer payrolls. It is also possible to provide a subsidy usable for any health benefits or to provide credit against payroll tax for costs of tax approved health benefits.

The State cannot mandate that employers or unions provide employee benefits, tax ERISA plans, directly regulate ERISA plans, explicitly target ERISA plans, or impose substantial costs on ERISA plans indirectly, through other regulations.

It is permissible to tax fully insured health plans, health care providers or employer payrolls. Its also possible to provide subsidy usable for any health benefits or to provide credit against payroll tax for the costs of tax approved health benefits.

ERISA facilitates challenges to state power. Randy Bovbjerg offered advice to the Authority suggesting that they use traditional state powers and target broadly, not narrowly, ERISA plans, that they share the burden of funding, and do not overburden challengers under ERISA, that the Authority focuses on revenue, not regulation, and engage in preventive lawyering.

Commissioner Thomas Sullivan asked about the Massachusetts plan and Governor Romney's ability to bring business to the table by addressing over-burdening and the 295 opt-out. Commissioner Sullivan asked if that should serve as a model for Connecticut.

Randy Bovbjerg explained that the 295 was the calculated amount per uninsured person that the state was paying for its uncompensated care pool. It is hard to know how much they could raise that number before there is an ERISA challenge.

Tom Swan suggested that there was an uncompensated care pool in Connecticut.

Angelo Carabba asked how taxation on physicians is dealt with in regard to future costs of care.

Randy Bovbjerg suggested it is more common to assess hospitals instead of physicians.

Margaret Flinter asked for an explanation of mandates with regard to ERISA.

Randy Bovbjerg explained that the benefit mandates can apply to the ERISA plan.

Margaret Flinter observed that it is worrisome that one can create major progress towards goal and you cannot wave ERISA rights. Does this mean that people voluntarily chose not to challenge but is always challengeable.

Randy Bovbjerg suggested it is not a privilege, it is a federal regulatory statute.

Sharon Langer suggested that the federal government will often regulate aspects of the healthcare system and to do so, a federal agency will often be involved. Sharon Langer asked for an explanation of a situation in which an ERISA challenge may occur and who may perform that challenge.

Randy Bovbjerg addressed the issue of who can bring litigation and under what circumstance. Those who may perform a challenge and the way that challenge is performed varies depending on the circumstances. There are different ways that the state and federal government interact, however, you cannot have a state-run ERISA plan.

Brian Grissler commented that as consideration of taxation increases for a series of organizations that are considered "tax-exempt," there is more incentive for those organizations to look for profit.

Margaret Flinter introduced Dr. Mitch Katz who has served the city of San Francisco as director of the AIDS office and the director of emergency medical services. He is a professor of medicine, epidemiology and biostatistics and he is acknowledged as a principal architect of the Health San Francisco Project.

Mitch Katz suggested that it would be necessary to be creative because the federal government has not been helpful in creating coverage for the uninsured in America. Judges pay attention to how our society is changing. Mitch Katz suggested that the process in San Francisco was similar to the process in Connecticut and it is the proper process by which you may arrive at healthcare reform.

Healthy San Francisco is a comprehensive medical care program for uninsured San Francisco adults. (uninsured children already are covered in San Francisco). Health San Francisco is not insurance. It a restructuring of county indigent health systems to encourage preventive care and continuity in primary care. No out of county service is permissible. A primary care home is provided as well as a comprehensive benefit.

Adults, residents of San Francisco, a 90 day period of insurance, and ineligibility for public insurance programs are required for eligibility for the Health San Francisco plan.

The goal of Healthy San Francisco is to make the city the first to provide universal coverage and to enroll 60,000 people. Currently over 20,000 are enrolled 10 months into the program.

San Franciscans have a choice of which primary care home they would like. The plan offers city-run health clinics, and private non-profit clinics. The only hospital is San Francisco General Hospital.

There are 14 public, city run, health clinics and 8 private, non-profit clinics. Expansion may include additional private clinics, private organized physician groups, and private non-profit hospitals.

Health San Francisco serves as a system of record. Before the system existed, no one was keeping track of patient records and there was duplication and unnecessary care.

Key access innovations include unified registration and system of record for all sites. There is screening for other public benefits. E-referral is used for specialty care. Clinic redesign includes a focus on a team approach, disease registries, and group education.

The cost of Healthy San Francisco is difficult to determine because no similar plan has ever been used. The full enrollment of 60,000 is approximately $171 million. Healthy San Francisco is financed through a combination of individuals employers, the City and County of San Francisco contributions, and other public sources.

Health San Francisco participant fees are based on the ability of those who are enrolled to pay. If an enrollee of the plan is making less than 100 percent of the poverty level, they will not be asked to pay a quarterly participant fee or fee as a percent of income. However, any enrollee in the plan will pay a quarterly fee based on their ability to pay. That fee will never be more than 5% of the enrollee's income.

There are also point of service fees that are based on ones ability to pay for the fee.

The health spending requirement refers to what businesses are asked to pay into the plan. This requirement is based on a per hour amount of employee work. Small businesses are asked to pay nothing. Medium sized businesses are asked to pay $1.17 per hour that an employee works. Large businesses are asked to pay $1.76 per hour that an employee works.

Employers may spend money on insurance, medical savings account, reimbursement from expenses, and/or the Healthy San Francisco program. The employer is asked to pay a "health spending requirement." This gives the employer options as to which program they would like to invest in, and should not be viewed as a mandate.

Over 700 businesses chose the city options. 16,000 employees are covered through those 700 businesses. $7.4 million has been generated from the employer contribution.

The restaurant Association has filed a lawsuit that the employer spending mandate violated ERISA. The district court ruled in favor of association and barred implementation of spending mandate. The ninth circuit appeals court suspended the district court ruling so the program is in effect pending appeal. The Supreme Court denied the association request to lift the appeals court decision. This does not mean that the Supreme Court will not hear the case later.

85% of the employers covered in the Healthy San Francisco model were already providing insurance. Therefore, the change created by the Healthy San Francisco project was not drastic.

In an interview with the restaurant association it was revealed that most of the feedback towards the additional restaurant charges were positive. In fact, 95% of the responses were positive.

Financing Healthy San Francisco is a shared burden. The City of San Francisco pays $123 million in redirecting of existing country funds for uninsured, $24 million in Federal health care expansion award, $15 million in employer contribution, $6 million in individual contribution, and $14 million in federal and state sources. We cannot continue to pour money into hospitals. There must be an increased focus on preventative care to help better our healthcare system.

Healthy San Francisco also has the ability to tap into Medicaid, Medicare, the AIDS Drug Assistance Program, Ryan White (CARE) funding, California Breast and Cervical Cancer Control Program, and maternal Child Health Program.

Healthy San Francisco provides a medical home, has predictable costs for members, is not a "charity care," program, encourages preventive care, offers customer service, health education, and care management, and decreases duplication and increases coordination of care.

Generalizable features of Healthy San Francisco include a focus on primary care home to reduce duplication of care and improve coordination, a centralized eligibility system to maximize public entitlement, a centralized system of record to create accountability, a non-insurance care model lowers costs and protects federal and state funds for counties, predictable affordable participation fees decreases client fear of large bills and facilitates preventive care, and a public private partnership maximizes available resources.

Lynn Price asked about the cost of visiting the emergency room for those who are under the poverty line.

Mitch Katz explained that the price of visiting the emergency room is waived if you need to be admitted to the ER. If you go to the emergency room but do not need urgent care you will be forced to wait until a doctor can see you and will be assessed a $25 fee. The price is designed to reduce emergency department visits.

Paul Grady asked for an explanation of the public-private partnership and how the private practitioner participates in the San Francisco model and how that practitioner is paid.

Mitch Katz explained that the public private partnership works weather you are a public or private provider. There are no invoice payments as a way of minimizing administrative expenses. Instead, private providers are given a grant based on an estimate on how many people they will serve in that year with a promise that they will increase the grant if they serve additional people. Clinics must give cost-reports. All hospitals in San Francisco are non-profit and are asked to perform charity care.

Sharon Langer asked about the payment rating system. In Connecticut, Medicaid is provided up to 185% of the federal poverty line. She asked how those who are making a smaller income are able to pay for healthcare in the Healthy San Francisco system.

Mitch Katz agreed that it is the lower income members that need special consideration. People tend to value things that they purchase, however you do not want to over-burden them. It is difficult to strike a perfect balance.

Dave Landsburg asked about the per hour rate that is paid by employers.

Mitch Katz responded that if the person has coverage from another place the employee may opt-out of the plan. Employers must demonstrate that the rate has been spent on an employee sponsored healthcare plan.

Sal Lucciano suggested that the plan served the poor well. Sal Lucciano asked if the plan eased pressure on the emergency room.

Mitch Katz suggested that the plan has been modeled as well as possible. The assumption was made that some portion of people were already being cared for, some were getting nothing and some were getting minimal care. For those who were getting minimal or no care, standard industry doctor visits and hospitalizations were used to predict the cost to the system and the public side increased its capacity and added a revenue source.

Sandra Carbonari asked about the medical home model that was used in San Francisco and what happens to a patient that shows up at a clinic that they do not have access to.

Mitch Katz replied that a person who shows up at the wrong clinic is directed to the proper clinic or may have the option of paying for care at a different clinic.

Franklin Sykes asked about minority population competency training and if cultural competency is available in the clinics.

Mitch Katz responded affirmatively. One public and one private clinic is designed specifically to the Asian population, two are designed to the Latino population, two are focused on the African American population, one is youth focused and one is gay and lesbian focused. One is not required to go to the clinic that represents their cultural demographic.

Franklin Sykes asked how transparency and accountability is performed in the medical home.

Mitch Katz replied that comes from the fact that every person is assigned to a particular home where there are certain care standards.

Franklin Sykes asked if tracking information including age and race was recorded at the clinics.

Mitch Katz replied that the data would be tracked by age, ethnicity and gender.

Margaret Flinter suggested that a major difference between San Francisco and Connecticut is that there is not a public health individual delivery care system. Margaret Flinter expressed her interest in coverage because coverage must be addressed before quality can be improved.

The meeting adjourned at 11:15 AM.