State-Wide Primary Care Access Authority

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Meeting Summary
Wednesday, June 24, 2009
Room 1D, LOB

Members Present: Dr. Daren Anderson, Evelyn Barnum, Margaret Flinter, Dr. Robert McLean, Lynn Price, Tom Swan, and Dr. Sandra Carbonari

Also Present: David Krause and Dr. Todd Staub

Members Absent: Comptroller Nancy Wyman, Commissioner Robert Galvin, Commissioner Michael Starkowski, Teresa Younger, Dr. Bob Schreibman, Glenn Chassis and Jody Rowell

Margaret Flinter convened the meeting at 7:40 A.M and announced that Joy Anderson will be speaking later in the meeting. As discussed at the May meeting, her presentation will be from the perspective of how people without insurance (or underinsured) pay for primary care and other health care services in the "cash market" We had discussed at our last meeting that it was worth having a look at innovation and how that might inform our thinking.

Margaret Flinter requested a motion to approve the Meeting Summary for the April 29, 2009 meeting.

Lynn Price offered the motion and Dr. McLean seconded.

Meeting Summary discussion:
Lynn Price: In the second full paragraph, it should refer to me, not Dr. Carbonari.

Margaret Flinter: On page 2, I had stated that DPH is doing a phenomenal job in organizing this response to the H1N1 outbreak so we will just add, "in organizing the response to the H1N1 outbreak"

Motion to approve meeting summary passed on voice vote.

Discussion:
Margaret Flinter asked Tom Swan to update the Authority on on healthcare legislation in Connecticut and at the federal level relative to our charge as an Authority.

Tom Swan: Folks are probably aware that two larger health care bills that were considered during the Legislative Session and have passed both the Senate and the House. Both the Sustinet Plan and the Health Care Partnership bills were delivered to the Governor yesterday and she has fifteen days from yesterday to decide whether to veto or to sign these bills. There have been mixed signals from the Governors Office on both bills. One of our big issues from last time around with the Health Care Partnership bill why she vetoed it was the concept of self-insuring the State Employee Insurance Plan, but her most recent deficit mitigation proposal included self-insuring for the second year of the biennium. Therefore, that was a big piece of her concern and there have been positive meetings in terms of Sustinet.

At the Federal level, stuff is going fast and furious/ what is amazing and something that never happen during 1993 is the three big committees in the House with jurisdiction over health care have come to an agreement on the framework and introduced a unified piece of legislation where in 1993 they never introduced anything. Senator Dodd is stepping in for Senator Kennedy in leading the charge in the Senate for the Health Education and Labor Committee. He still voices some hope that he may finish marking-up their legislation by the end of the week. That will be surprising if he able to do that considering the most contentious items have not been scored by the Congressional Budget Office, which we expect to have, if they did not get it last night, sometime today. In addition, the Senate Finance Committee who has not began to markup their bill and will wait until after July 4. Recess in part, because it came back with 1.6 billon dollar fiscal note or a trillion dollar fiscal note over ten years and it did not cover everybody so they have been making some significant changes. Tomorrow I will be in Washington with at least 10,000 of my closest friends for lobby day on this issue.

Margaret Flinter: I will add that on the federal side that both bills are available online and I do not know if people have a chance to read them, but relative to the charge of our Authority, there is certainly a big focus on primary care. Because workforce was ending up in so many element of everybody's work, Patty Murray, from the State of Washington has been charged with the workforce issues and specifically workforce around primary care. Therefore, if you read the draft there is a lot of focus on increasing training, on trying to increase prevention and increasing support for primary care providers. There is nothing very specific that I have seen about differential payments for primary care providers or things that address some of those fundamental issues. At least the issue is all the way through.

Dr. Robert McLean: There is a very big bill that was introduced in the House, the main sponsor is Alison Schwartz, which pushes primary care, the patient centered medical home and increasing role of the Nurse Practitioners. It addresses some of the pay issues and the ACP kind of endorsed that and presented that when she presented that in mid May. I do not think she is under the illusion that it is going to actually be a separate bill, but that it will kind of wrap into everything. They were waiting for a Senate bill, and finally after much delay it was presented by Maria Cantwell.

Margaret Flinter gave an update on the online licensing project at DPH. It continues to move forward and the DPH staff tells me it is right on target for July 15, 2009 roll out. It would be a great step forward to have all that data that we asked to be included from the New York State Survey.

The focus of the meeting turned to the final report. Margaret asked to review the outline of the final report and distributed a document that is just a compilation of the early drafts of key sections.

Margaret informed the Authority that she does not think it is possible to take on the writing of this report within the Authority. She has reached out for assistance to local foundations to support getting help from the consultants who assisted with the HealthFirst report. She noted that she assumes everyone on the Authority who has volunteered to help with the writing is extremely busy, and it would be easier for them to be editing and updating and finding the integrations with other sections than doing it solo. Finding somebody to write the report will allow us to have a good and polished final report.

Dr. Daren Anderson: I think the process of starting to get thoughts on paper is incredibly helpful. This document is all the research that I have been pulling together so far and I see there is some overlap because several of us worked on similar area. But I think, the more that each of us write, we will have the body and then it can all be pulled together.

Dr. Daren Anderson: I am finding it easier to write about the general topic, the importance of improving access and the health care coordination and I think it would be helpful for us to discuss this as a group.

Dr. Sandra Carbonari: I agree with that as I struggle with the level of details and how specific do we have to get with recommendations.

Do we want to be throwing out relatively broad goals or specific things- how do we really word our recommendations? I think we want to give as much directions as possible without tying hands and how are the Legislators going to perceive what we tell them or suggest.

Margaret Flinter: I think the work that we have done with the online relicensure is a great example. We have to know where we are in terms of both the current and the projected pipeline of primary care providers. Everybody can agree that there is both a broad issue (having the data to make workforce planning decisions) and specific issues (what is that data and how can we ensure we collect it).

It does not work that easily in everything but if we look at things like care coordination, everybody has talked broad brush, a few states, groups, and individuals have proposed specifics. Even if we don't have a specific recommendation, I think it is helpful if we point to other people who have done some tangible work in that area- I think it's a given that we all believe that primary care should be covered and every body ought to have coverage . However, we also know that we do not have it today, so what are we doing on the short term while we continue to work towards everybody being covered.

Evelyn Barnum: In terms of process, I appreciate that this process is public but if I would be willing with the other writers to spend sometime on conference calls even if we recorded them because I would benefit from sort of understanding the group think with whoever are the coordinator

Margaret Flinter: Can we do conference calls as an Authority? We will have Beverley check, if it is specific for the purpose of reviewing and editing report.

Evelyn, I do not think most people know the depth of the sort of expansions that might be going on within the community health center movement based on the expanded medical capacity money. And at same time we have the Legislature looking to cut back the funding to community health centers which I think has a pretty significant impact in terms of our capacity here in Connecticut.

Evelyn Barnum: I think there have been four important opportunities. First, Margaret is referring to money the Bureau of Primary Health Care allocated to 330 funded health centers (FQHCs) in the state, called "Increased demand for services funding". This was $3.5 million-- the exact amount of the cut to the DPH funding for the community health centers. However, federal funding are not been given out to supplant the states obligation so I think we might hear from the feds about that. There is also a round of Capital Improvement Project money (CIP) which was a formula and the health centers could use it for HIT and other capital improvement. Over the weekend, facilities improvement funding came out, which is a much more competitive process and larger amounts of money for expansion of the health center facilities. Then in the mix along with ARRA and the health center appropriations there have been disbursements of expanded medical capacity funds for applications which were approved but unfunded, as well as new access points, and in Connecticut there were three of those, in Putnam, Torrington and Norwalk. There may be one pending for Danbury.

We also anticipate that there will be other service expansion opportunities as well as other new service point opportunities. So through the ARRA and the increases in the health center appropriations, there have been these huge infusion of cash for not only infrastructure development but also for operating funds for primarily services to the uninsured as well as expansion. With IDS we did a little rollup, there have been many new positions created, lot of FTE and positions preserved as well as projection of additional visits that will be provided to new patients. So the pressure is on the health centers to perform under the IDS, which is not going to be possible if at the back of this we have the DPH money not available and we need to be really working on not having the effort for increase services undermined by the state budget crisis.

National Health Service Core big change was that with the additional changes, they have made many more slots available, and its related, the placement of National Service Core loan repayers is related to the health professional shortage area scores for the regions that they are in. the fact that it's easier to qualify for a loan repayer, hopefully will mean that there will be more places through the usual process, in addition to there being more slots.

Margaret Flinter: I think this becomes sort of an additional section in our report because it is new since Dr.Trestman did his work, but it is really an expansion. There are also pending significant changes to how the loan repayment program is administered, with the possibility of pre-qualification at the beginning of your medical/nursing/dental school education.

Dr. Sandra Carbonari: There has been some direction to DSS to do an expansion and they are gearing up for that. It is called, HUSKY Primary Care, and its Connecticut's Primary Care Case Management Program. There is a brochure that explains the whole concept and this is aimed at patients and there is supposed to be a mailing going out, first to the Waterbury and Windham areas. Initially the only patients that were invited into this were patients that were already a part of those practices. Now, there is a mailing going out to all HUSKY Patients in that catchment area. They are going statewide January of 2010; they are expanding in those two pilot areas first and then they are going to go statewide. The Provider Advisory Group has been working very hard on telling providers the basic things they need to do to be eligible for this extra funding as far as care coordination, disease management and quality improvement.

Margaret Flinter asked Dr. McLean if he would talk with the physician community through ACP or CSMA about the response to stimulus funds for adoption of Health Information Technology and report on that at the next meeting.

Dr. Robert McLean: Todd, at the last meeting, seemed a little bit more up-to-date on some of that, but I can do some homework on that. I think from what I understand, having talked to my group recently, is that the money that got put into the stimulus package is not slated to be released/disbursed until 2010 or 2011. I do not think any of the 19 billion is slated to be disbursed in 2009.

Margaret Flinter: I believe it's allowable, and it can be disbursed through reimbursement, through paying you back for the expenditure of implementing electronic health records. And I thought that one option is to start now knowing that they will be reimbursing when that money is released.

Dr. Robert McLean: Right, I think there are some issues. I think you must have demonstrated or initiated meaningful implementation of electronic technology whether EMR or E Prescribing and I think one of the hang-up is that it is very vague. I think the definition of "meaningful" remains to be defined as it is a moving target and the physician community is basically saying, oh we need to start this process to be ready and I think that whole industry is now being created that will be trying to get physicians and hospitals to up to speed. It has been an economic stimulus to those industries thus far.

Presentation:
Joy Anderson, PhD: President and Founder, Criterion Ventures, Founding Partner, Good Capital

Introduction by Dr. Anderson: Criterion has started looking at the question of medical debt that was the presenting, exploding issue around bankruptcies and medical debt, and the impact on access to care. People with medical debt have the same care-seeking behaviors as the uninsured. That is where we started. The challenge was that once you are in debt it is past the problem, all you can do is refinance the debt. About 2 years ago we had an idea to create a "Fannie Mae" for medical debt as a serial entrepreneur they are a set of ideas. I am glad that we did not follow up with this idea. About a year and a half ago Rockefeller Foundation gave us a significant grant and over the last year and half they have given us about 1.2 million dollars to look at the question of the uncovered cost of healthcare. So what I want to walk through is the logic of our thinking. Healthcare is complex and so I will skirt over details to get the whole theory out there.

The promise of healthcare uncovered was to look at the impact of the uncovered cost of healthcare and to say how do we get prices to go down, access to care to increase, and how do we get transactions to be more efficient and eventually allow for broader innovations. We have come to believe that many of the barriers to innovation, particularly in primary care, come out of the payment systems. There is a block to thinking about innovation because of how payment happens. This starts with a re-conceptualization of the problem.

The current understanding seems to be that you have public programs and private insurance and our entire job is to close that gap. That would give us universal coverage, and eliminate the divide between those two at some point. Until then we have been pushing to close the gap.

We reframed the question, to say, if you think about that gap, that gap is $265 billion dollars paid out, by individuals in some form of cash or credit. It is 15% of the overall healthcare market. Therefore, you start to say, "Maybe this gap isn't a gap, but is its own market". Therefore, that was our reframe. We said, rather than seeing cash and the payments that individuals pay, or do not pay, rather than thinking about it as a failure of the insurance market, we could think about it as a failed market in its own right. This very much comes from our own frame. As Margaret mentioned we sit in the social venture space of for-profits, not-for-profits, business and social change, whatever name you want to put on it. We see things often from the frame, of, "if it's a market failure, let's first look at how we can remedy the market, and then think about subsidies". Poorly formed markets have very traditional characteristics, prices are erratic, transparency is difficult, etc.

That is the backdrop. Rather than seeing this cash market as a failure of insurance or public programs, can we think of it as a market in its own right, where we can have some kind of impact?

Dr. Robert McLean: I agree completely with what you are saying as far as the cash market. I would expand that and say that all of this dysfunctional market stuff applies to the dominant market. So it sounds like kind of where you are going is to fix the small market. Now if the small market is messed up because the large market is messed up, maybe some of your market reforms need to be addressed at the whole market. That is basically saying that the insurance set-up as it currently exists is completely dysfunctional, which I think everyone agrees it is. Which means it is a much bigger nut to crack. You are saying "let's fix the small market", but the whole market is in fact what you are describing.

Joy Anderson: I agree. Two things have happened in the last year since we named the problem. One is that if you take the government programs, we have had a consistent experience to try to think about this in new ways. The second is, a lot of the ways that we are trying to inform insurance, decrease utilization by use of copays, increase deductibles so we can afford insurance, all of those play out in the cash market. We see it is a place for innovation and leverage for 2 reasons. One is if we change something in the cash market we can actually tilt the windmills at the larger system. People have thought for a while that if consumers actually thought that their dollar was meaningful in healthcare they might make better decisions, which is not a proven thing. There are some questions around that. But if their dollar did actually have a meaning in the cash market, that would help. The problem is now that if I pay $50 at my doctor's office, I don't actually have leverage. I am paying $50 of a $1000 bill that is nuisance money in the system. One of the things from a justice point that makes me irate is that the $50 that could be the difference between eating and not eating for a family, is nuisance money in the larger system. For me that is a justice issue. If we can actually empower people to see their $50 as having power and actually create financial systems that allow it to be that way, we will be in a better place, so tilting at windmills, yes.

Dr. Robert McLean: At the same time that fifty dollars is peanuts compared to that $1000, and out of that $1000, $200 is going into the insurance company's pocket. The $50 is meaningless, except to that family. So I agree with what you are saying. My point would be that everything you are saying about reforming the market needs to happen at the higher level because unless that bigger market is reformed, that co-pay is going to go higher and higher. Eventually, maybe, your cash market would be huge because the insurance companies are not going to pay for anything.

Joy Anderson: I would say the second place, and this will frame what we are looking at, we define the cash market as things you can imagine paying with cash. So insurance should cover the "I got his by a bus" scenario. You shouldn't pay cash for getting your body reconstructed. That is why we have insurance. So when we are talking about the cash market, we are talking about the kind of transactions where you and I could sit face to face and agree on a price for a particular activity. That is not necessarily what is true in all parts of healthcare.

Our theory of change: healthcare is local and therefore we work locally. Healthcare money is local, healthcare provision is local. We have to organize the whole community. A large part of what we are doing is hard core community organizing. It isn't a magical technological switch. Nor do we believe that a single reform will change the whole system. Because of the level of fragmentation this is a fairly slow, tedious process of community organizing. We work through affinity groups, we cannot see this as a consumer issue where every consumer acts individually. We work with affinity groups to say how do you organize affinity groups in such a way the en masse they can have buying power, which is very similar to what insurance did. We prioritize transparency simply because it is one of the driving issues in a market. Finally, the sort of timed value of money which means that cash should have more leverage. We define our final outcome as an increased value of the cash-dollar in healthcare. So if the cash-dollar has more value in healthcare we believe that will affect access, price, and all of the other things that we talk about as the primary drivers in healthcare.

Dr. Robert Mclean: I don't mean to be the nay-sayer, but one of your major premises is that healthcare is local, I would say I don't think that is true because the dominant insurance players are frequently multi-state or national and part of the policies that they declare are in other states. When you locally try to make an objection or change a policy the answer is "sorry" from big brother in the other state, which is why a lot of state regulations and effort fail. At the cash level I think you are right.

Joy Anderson: Because we are focused on the cash level we can negotiate with a large employer in a community. They are quite open about how they can get primary care dollars to their employees, not necessarily through their insurance system. This is the other thing, in all our meetings and summits that Rockefeller funded, no insurance company sat at the table. We have intentionally avoided becoming a program of an insurance company, in fact, we would prefer to be regulated and have the cash market regulated as a baking or larger financial services transaction. I think one of the challenges we have in health care is that we see insurance as the dominant metaphor for how to do financial services in healthcare. That is a ridiculous frame. Financial services are a rich, abundant, sometimes screwy, industry. We use one of its tools in healthcare like a club over and over again.

One of the first things we are doing is a set of market formations. This is Criterion's work right now. No one knew the cash market existed, it was called by many other names. To be able to reframe the issue, and one of the core pieces that we are trying to bring to DC right now, is just let's not think about only insurance as the tool. How do we expand the set of tools that we use, to think about paying for healthcare?

The second piece is community organizing. Right now we are focused in Memphis, Detroit and Alameda county, figuring out how to map the cash network in those areas. We never did huge statistical studies, we are sort of scrappy entrepreneurs. Part of what we are doing is on the ground, in individual communities, really trying to understand how the cash market works in those areas.

Finally, we have a product strategy. We think the place we can have impact is essentially through a rules engine. Within the cash market the money is very fragmented. You walk into a doctors office figuring out is this going to be paid for by personal dollars, my HSA dollars, is it part of my insurance coverage, is it part of a separate program that is offered by the county? The basic proposal that we have is to have a health card. That health card is essentially driven by a rules engine that says at this provider event, this type of service, we can pull money from this purse, sitting on your card. But the basic underlying driver is a multi-purse card. I could have county dollars, personal dollars, something like SEIU's prepayment program, hospital charity dollars, a line of credit, and other kinds of payment. There is an unlimited kind of purses that any card could have. A card could have 100 or 200 purses and they could have $10, or $50 or $1000. They would say, based on this event, here is what should happen. Those get driven through those affinity groups and then should eventually shape the delivery system. So for this moment in the delivery system, because I sit in these affinity groups, and because I sit in multiple affinity groups, I can draw from this purse.

So the basic work that we do as a company is the community organizing that actually allows those conversations to happen to figure out there are diabetes dollars to get into the hands of people to encourage certain kinds of behaviors. How do we put that on a single card? Many of the cards that are working on prepayment are one to one. You get a card for a service. Individuals are not going to manage 15 cards in their wallets to figure out which one.

So how do we start to synthesize those into one card? How it works is a rules engine that sits behind the company in the back office. The company that we are working with has 100,000 of these up and going. It is tested and it works. Then we can add all kinds of other innovations to that. You can add instant adjudication if you are working with an insurance company. You can actually bring in a negotiated fee schedule that would sit on top of that, and electronic payment.

Let me go through 2 examples. In the first model, imagine a community health department, what we are talking about doing in Alameda, literally the eligible population uses the card to access its benefits. Rather than an ID card it is actually this card that makes these transactions happen. The first thing that could happen is if you have a Visa card, it would be driven by Visa. You could present that in a provider outside the public system. Currently the county benefits work solely within the public system. You could walk into any number of systems and as long as the negotiated rates played out you could walk in with your card. Then imagine other benefits being added on. There is a problem with the number of people who call for emergency transport. If you are elderly and you are calling for emergency transport because you need to get to a doctor, what if we had taxis, literally preloaded onto the card. They could call the nurse hotline and figure out that they can actually just call a cab. Then you start adding onto that because as we think about building a cash network, we start with one affinity group and one purse, then go to the next affinity group and the next purse relationships with the provider system and keep building that, we will eventually end up with a cash network, where money an fundamentally flow in different ways. So as we go through that the hospital starts working with a credit union to put dollars to the credit union members to be able to divert them from the emergency room and into incentives for FQHC's to stay open late at night. It is an innovative system in which hospital dollars are being put on the card to drive it. You can imagine it going even further to say what if it covers healthy behavior and not just traditionally thought of costs. You could put $20 for a farmers market, this is an example from Alameda where there is a significant lack of fresh produce in poorer neighborhoods.

The second one starts with your traditional poverty line, 200%, 300% of the poverty level or below, borderline economic categories. The second one starts with a large employer. We are actually doing this with a national pension fund right now where the employer is able to put multiple pots of money on this card, a line of credit, an incentive for healthy behaviors. This could expand to a community bank that offers the card, which would have a different qualification process. Potentially the fee schedule could come out of a community bank. What we are trying to do is reorder. What if the community bank, through offering this card, got access to a fee schedule that was appropriate for the people it worked with? We are reorienting the traditionally lines of how money moves within healthcare so that we can break open some possibilities which hopefully leads us to questions of impact.

We have got to figure out how to bring down prices and make prices possible within primary care. Appropriate pricing within primary care becomes a fully important issue. When providers need to be paid more for the services they are offering, to be able to have incentives to draw people into the field and not have it go out the door in administrative costs because the collection rates are so low. Long term as we look at this, the system renovation is what is most important to us. We believe in looking at the cash market, working with patients providers, payers across the board, more responsive financial mechanisms will allow us to have a platform for more innovation. Whether it is the card or another way of looking at the cash market, it doesn't really matter, what matters is that we start thinking about how money is moving within the cash market and thinking about it holistically as a place of innovation, as opposed to a failure of 2 other sets of work.

Margaret thanked Joy for her presentation and invited questions and discussion.

Dr. Robert Mclean: Just one other thought, the instant adjudication idea is interesting, I think that the reality is that there are a percentage where it is really difficult to understand, based upon the patients deductible, how much they have met, exactly what the policy covers and doesn't cover to know, at the time of service, how much the patient actually owes in cash. So it has to go through the billing cycle, and the insurance companies don't mind things going through the billing cycle because they are holding on to their money longer. Whether the insurance companies, that you have not been speaking with, are going to be interested in allowing a quicker adjudication, I would be pessimistic.

Joy Anderson: Yes and I think that's why it is a, what can be built onto the platform, because it is possible to do it at point of payment if the insurance company is willing to do it. All the system needs exist, and one of the biggest barriers to using them is not the insurance, it is the employer, or manager of the plan. The manager of the plan's goal is to have as few inaccuracies as possible. There will be more inaccuracy if you don't go through the billing system. The cost of those inaccuracies, the 1% exception rate, would easily be covered by the 5% it costs to do it the other way. So the barrier actually sits more in the fear of the mistakes from instant adjudication than from the insurance companies. Because, if the health plan manager was saying "I want this from the insurance companies and I will go to a new plan if you don't give it to me", the insurance companies would pony up. But the health plan managers, the middle level, are not going to take the risks.

Dr. Daren Anderson: Thanks for your fascinating presentation. I am wondering if this has some implications for concepts like value-based insurance. I worked for a company for 10 years whose slogan was "Healthcare is a right not a privilege". I think the problem with that statement is that healthcare is a

right and not a privilege. I think that going forward as we look at the enormous differences in expenses and in what different organizations pay for, ultimately we are going to be forced. We are already in a position where we cannot afford to do all the things we want to do and I think that in the near future where we define a minimum set or benefits that are evidence proven and have good support and are covered by whatever plan you have. But additionally, if you want the non-generic medication, if you want a face lift, whatever the things are that have less evidence around them or are considered non-essential, would have more contributions from patients. I am wondering if this would be a mechanism to work that concept into value-based insurance.

Joy Anderson: Absolutely, I would take it a little bit out of the model of value-based insurance and say a value-based payment system. What you are seeing in some local areas is employers saying let's skip the intermediation of the insurance, let's work directly with the providers and have a preferred set of provider networks that we can negotiate with. You can imagine the same thing happening with counties, state governments, FQHC's and other community based organizations to say these are the things that matter, and we just want to pay for them frankly. We will pay for them at a premium if you make them available in a timely way that is convenient for out workers. You are seeing this exploding with employers and they are bringing them into their shops so that they have health care. Across the board you are seeing, how do we actually get health care much closer to where the people are. In that, how do we decide what good is, and what is valuable? That is kind of an open question, is it good medicine? How do we work to still keep that value of what is important but break it out of the traditional strangle hold that I believe it is in, of seeing what will plans cover.

Evelyn Barnum: I love plastic because it accounts for every penny that you spend. This is going to throw off a tremendous amount of information and I am sure you have thought about how powerful this will be and what you will do with that. It will track, in a system, this $265 billion that is not accounted for.

Joy Anderson: From the beginning we have talked about "religions" in healthcare. One is the medical information card, and so from the beginning we have seen this as an interesting alliance with people who are looking at those kinds of systems, and how can we share it more easily. Most of it has been, how can it help, and one of the real challenges is that no one counts this money. We cannot figure out where this money goes and it is so fragmented. We are looking for the question of leverage in the broader system, and if we say, look we can move more dollars at lower cost in this way, that is what I care about. I need that data to be able to prove that point.

Margaret Flinter: Joy, one of the main reasons for my interest in your work is our charge as the Authority to come up with ways to guarantee access to primary care to all residents of the state of Connecticut. There have been a number of elements in that, from the pipeline, workforce, recommendations on legislation to make sure there are primary care providers, and insurance. One of the sticking places for me is that at a minimum we ought to be able to guarantee that everybody has access to everything that is on the US preventive services task force. It seems to me that we should at least be able to say to the uninsured either you have free access to that, or you have a card of some kind. I wonder if you have looked at this specifically from a set of services that everybody needs to have. What we know is that what patients are most worried about is what gets you into medical debt, which caused you not to get the care that you need. Have you had any specific thinking around sets of coverage or ways at getting at those preventative services?

Joy Anderson: I will say that we are working with Reform Church of America as a national plan, and they are really building to say how do we start to strip out of our traditional insurance plan, the things that we just want everybody to get, and put that on a card, as cash.

Margaret Flinter: So who has done the card?

Joy Anderson: No one has done our card. We have not implemented it, we are still in the garage phase. We are still working out what the design would look like in the three communities that are the primary places. That is escalating as our work is becoming more and more visible. The provider that we are working with, the technology provider, has had this up and running for 8 years, in general. This is the rules engine behind it, so we don't have technology risk within the system. She can essentially put whatever rules you want behind a card, and it swipes like a Visa. At a doctors office you have to make a phone call or web interface to make sure that the code works. You swipe it for security reasons. It is working now, a couple 100,000 people have these cards now. The world is sort of our oyster. Again, it is the what care and services potentially in what provider networks, for whom, and where does the money sit behind it. If we know the answers to those questions then it can be put together any way you want it to be. The idea behind it is that once you have those on the card, could there also be a line of credit for additional things, etc. Because what doesn't work in people's financial realities is a card that only does one thing. Obviously the good thing about HSA is that they made it absolutely possible to say that I am going to swipe this at a gas station to buy beer and it gets rejected. So we can do those kinds of things and instantly reject it to make sure we get the most available kinds of financial transactions.

Margaret Flinter: I know it sounds kind of far-out-there, talking in our current economy about anything that requires any kind of expenditures. I continue to think that unless there is a strong element of innovation in everything we do in healthcare reform we are going to end up spending a lot more money without getting the results we need and if there is a way to drive towards primary care towards the preventive services that we know people ought to get and at the same time engaging consumers, that is a step forward.

Joy Anderson: I would encourage you to not think of that as we need to go to the legislators and say, "we need this money", because there are actually multiple people who would chip in. We are starting to see things like Vita-card and other things that are funded by the employer dollars. So rather than saying the uninsured is a gap that needs to be filled by the government, when they are paying for it simply because there isn't a mechanism to get the money from other people who are interested in paying for the same thing, this is where we have a failure of imagination.

Margaret Flinter: I think it's a great point, and I would really appreciate you keeping us updated on the progress and particularly since you live in Connecticut we are fortunate to have you here thinking about how this works in an economy like Connecticut where we have many elements of the uninsured from the 20-some-things, to the undocumented who worked to other people and a whole range of services out there that people can often access if they can get thought the gateways. The retail clinics are one, the flu shot at Walgreens is one, , the breast and cervical cancer screening, colonoscopies, you can get all these things in Connecticut, often with no funds, but you sort of still have to have a connecting pathway to get there so that is very interesting.

Joy Anderson: I re-enforce the point of undocumented workers. They are never going to be covered under any of this. We were actually in D.C. and a few people are going to be coming together to say, after this legislation passes, what are we going to do about undocumented workers, and what is the role of this kind of technology to be able to move some money, and working with the really good work that is done with banking the un-banked and how to get access to financial services. That is the barrier, undocumented workers walk in with cash. So we found in Memphis a story of people walking in and paying rates for services in cash, tracked where those people came from, found out that they all came from the same congregation of a church that was passing a hat on Sunday to make sure that they weren't perceived as a "problem group" at the hospital. So the hospital said we will work with this church and make sure that when you send folks to us, you will pay what the insured pay, and less to us, not what you pay for the insured and lets try to figure out how to move that money in a safer way. So, we are working with them to use this card as a mechanism.

Dr. Robert McLean: The last example was a great one. The reason why they were getting charged so much was because the rates are so high because of the current insurance market and cost-shifting. I think the ideas that you are presenting are very innovative and interesting, while they might work as you currently state them, they would definitely work well if you had a transparent more user-friendly insurance industry.

Margaret Flinter thanks Dr. Anderson for her time with the Authority and announced the PowerPoint would be up on the CGA website within a few days.

Tom Swan announced that the next meeting would be on July 29, 2009.

The meeting adjourned at 9:00 am.