APPROVED

Legislative Services Agency

MINUTES

Legislative Commission on Affordable Health Care Plans for Small Businesses and Families

June 20, 2007 First Meeting

MEMBERS PRESENT:

Senator Jack Hatch, Co-chairperson
Senator Jerry Behn
Senator Joe Bolkcom
Senator Larry McKibben
Senator Amanda Ragan
Mr. John Aschenbrenner
Ms. Amy DeBruin
Mr. David Carlyle, M.D.
Ms. Barb Kniff
Mr. Timothy Kresowik, M.D.
Ms. Julie Kuhle
Ms. Jan Laue
Mr. Eric Parrish
Ms. Patsy Shors

Representative Ro Foege, Co-chairperson
Representative Mark Smith
Representative Linda Upmeyer
Mr. Russ Sporer
Ms. Sarah Swisher
Mr. Joe Teeling
Ms. Sharon Treinen

Ex officio members:
Mr. Kevin Concannon, Director, Department of Human Services
Mr. Tom Newton, Director of Public Health
Ms. Susan Voss, Commissioner of Insurance

MEETING IN BRIEF

Organizational staffing provided by: Ann M. Ver Heul, Legal Counsel, (515) 281-3837

Minutes prepared by: Patty Funaro, Senior Legal Counsel, (515) 281-3040

I. Procedural Business.

II. Health Care Landscape in Iowa — Iowa Insurance Division (IID).

III. Health Care Landscape in Iowa — Public Programs — Department of Human Services.

IV. Health Care Landscape in Iowa — Providing a Health Care Safety Net.

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Legislative Commission on Affordable Health Care Plans for Small Businesses and Families

I. Procedural Business.

Call to Order. Senator Hatch called the initial meeting of the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families (the Commission) to order at 9:02 a.m. on June 20, 2007, in Room 103 of the Statehouse.

Co-chairpersons. In accordance with 2007 Iowa Acts, chapter 218 (H.F. 909, section 127), Senator Hatch and Representative Foege were selected as the Co-chairpersons of the Commission by legislative leadership.

Adoption of Rules. Senator Bolkcom moved adoption of the rules as distributed, and Representative Mark Smith seconded the motion. The motion was approved on a voice vote.

Addition of Commission Member. A motion was approved on a voice vote requesting that the Legislative Council approve the appointment of a representative of the Iowa Dental Association to the Commission as an ex officio member to the Commission. Steven Fuller, D.D.S., was introduced to the Commission as the nominee for this appointment.

Introduction of Members and Discussion of Commission Objectives. Following introduction of the members, the co-chairpersons discussed their objectives for the Commission. Co-chairperson Foege noted that the resulting product of the Commission would have to be workable and rational and based on adequate and accurate data. He emphasized the need for all members to be involved and to share their expertise. Co-chairperson Hatch noted that the recommendations of the Commission would have to provide for affordable, accessible, and quality health care for all. Co-chairperson Hatch also emphasized the need for all members of the Commission, to be involved and that all members are equal participants. Co-chairperson Hatch noted that in addition to the meetings of the Commission, former Governors Terry Branstad and Tom Vilsack have agreed to hold three public hearings regarding health care in September at the proposed sites of Council Bluffs, Davenport, and Indianola. The four caucus staffs and the Legislative Services Agency will coordinate the public hearings. Co-chairperson Hatch stated that the Rebalancing Health Care in the Heartland Forum held on June 19, 2007, and attended by many Commission members was very valuable. Co-chairperson Hatch also mentioned that the Commission would be assisted in its work by a Health Care Data Research Advisory Council, established in accordance with the legislation.

Website. Ms. Ann Ver Heul, Legislative Services Agency, Legal Division, and staff to the Commission, reviewed procedural issues with the members. She also discussed the Commission website and the future creation of a monitored bulletin board to receive input from the public. Commission members were asked to submit questions to post, on a monthly basis, on the bulletin board.

Adjournment. The meeting was adjourned at 2:18 p.m.

Next Meeting. The next meeting of the Commission was scheduled for July 18, 2007, in Oskaloosa, Iowa with the venue and time to be announced at a later date.

II. Health Care Landscape in Iowa — Iowa Insurance Division (IID).

Commissioner Voss presented information regarding the insurance market in Iowa. She discussed insurance regulation, the current landscape for small employer group insurance, the individual market, the uninsured rate, new initiatives not yet implemented for 2007, and consumer concerns and complaints.

Insurance Regulation. Commissioner Voss noted that the IID regulates companies doing business in Iowa, agents and producers selling insurance in Iowa, certain rates and forms, public self-funded entities, Multiple Employer Welfare Arrangements (MEWAS), the Health Insurance Plan of Iowa (HIPIowa) for high-risk individuals, and third-party administrators. Conversely, IID does not regulate Medicaid, Medicare, private self-funded health care plans that are regulated under the federal Employee Retirement Income Security Act (ERISA) by the federal Department of Labor, and other federal programs. Due to the exceptions in regulatory authority noted, Commissioner Voss estimated that only approximately 25 percent of the health care dollars expended in Iowa are under the regulatory purview of the IID.

The IID includes a Company Regulation Bureau that provides for financial examination of insurers; a Market Regulation Bureau that receives consumer complaints, and provides for enforcement, rates and forms, agent licensing, and the Senior Health Insurance Information Program (SHIIP); a Fraud Bureau that investigates alleged fraud in the insurance industry and market; and Administration that provides for the development of legislation, administrative rules, and insurance consumer education and outreach.

Small Employer Group Insurance. In the small employer group health insurance market, a small employer is defined as an employer with two to 50 employees. There are currently 28 carriers selling in the small employer health insurance market in Iowa. However, six of these, Wellmark, Inc.; Wellmark Healthplan of Iowa, Inc.; United HealthCare Plan of the River Valley, Inc.; United Healthcare Insurance Company; Principal Life Insurance Company; and Coventry Health Care of Iowa, control 91.5 percent of this market. The control of the market share by just a few companies, however, is not atypical of the insurance market in other states.

With regard to rates, Commissioner Voss provided rate comparisons based on various studies. According to a Medical Expenditure Panel Survey, for the employee-only yearly rate, Iowa ranked 16th at $3,561/annually; for the employee plus one coverage rate, Iowa ranked 8th at $6,586/annually; and for family coverage, Iowa ranked 12th at $9,422. The small group average monthly premium was determined to be $747 by the American Health Insurance Plans (AHIP), $881 by David Lind and Associates, and $846 by Wellmark Blue Cross and Blue Shield.

With regard to rates, Commissioner Voss stated that one must be very cautious in comparing rates between states because states vary as to mandates, the definition of creditable coverage, and other variables. Additionally, Commissioner Voss stated that in Iowa rates are certified as following statutory guidelines, but are not preapproved by the IID. If a consumer complains, however, the IID will conduct a review. The IID does not review health care costs and reimbursements, only the premiums. Approximately 85-86 cents of every premium dollar in Iowa goes toward health care costs with the remainder going toward administrative and other costs and profits for the insurer.

Coverage requirements in Iowa for small employer group insurance include guaranteed issue to guard against "cherry-picking", guaranteed renewability to provide for continuation of coverage, portability in moving from the small group to the individual market, mandates which currently number 28 in Iowa and make up 10-15 percent of the rate (Hawaii and Utah rank lowest in mandates at 22 each and Maryland ranks highest with 60), mental health parity which provides coverage for biologically based illnesses, an external review procedure to determine the medical necessity of a treatment, and an experimental treatment review.

Individual Market. Commissioner Voss stated that the individual market is similar to the small group market with regard to mandates and coverages. Rates are preapproved based on statutory guidelines. The individual market is subject to guaranteed renewability but not guaranteed issue.

Uninsured Rate. Iowa is in 3rd or 4th place among the states with the lowest number of uninsured with approximately 9.1 percent of the population uninsured. Approximately 5 percent of children under 18 make are uninsured and approximately 11 percent of adults are uninsured, based upon a recent Commonwealth Fund report.

New Initiatives. 2007 Iowa Acts, chapter 57 (H.F. 790), includes provisions relating to Association Health Plans. The provisions included allow associations or groups of associations to band together in the same class for the purposes of rate setting. Commissioner Voss noted that even though this might not drastically reduce premiums or costs, it might reduce the rate of increase. Additionally, H.F. 790 provides incentives to employers to include wellness incentives in their health care plan offerings. The IID is currently reviewing the experiences of other states to develop rules for the wellness incentives by the end of the summer.

Consumer Concerns and Complaints. Commissioner Voss stated that consumers generally voice concerns and complaints regarding cost, complexity, and coverage. The majority of consumers do not read their health care policy until they need coverage. With regard to coverage, the main issues relate to who is included in the plan network and preapproval for the provision of health care services.

Discussion. In response to a question regarding the comparison of Iowa to other states, Commissioner Voss responded that the devil is in the details and that it is difficult to compare insurance across state lines. With regard to HIPIowa for high-risk individuals, Commissioner Voss estimated that the cost per individual per year might be 50 percent higher than average.

Regarding the limitations imposed by ERISA, Commissioner Voss stated that nationally, insurance commissioners lament that there is a whole segment of the insurance industry that states can not do anything about. A frustration is that when a consumer has a complaint regarding a self-funded health care plan, they must go to the federal Department of Labor which is not equipped to respond to consumer complaints.

In response to a question regarding the determination of minimum coverage, Commissioner Voss stated that pursuant to requirements under the federal Health Insurance Portability and Accountability Act (HIPAA), states are required to define creditable coverage to allow for portability to other types of coverage.

Senator Bolkcom asked that Commissioner Voss provide the dollar figure that equates to the market share represented by health care plans subject to and not subject to ERISA.

Representative Upmeyer asked that this information also include the number of covered lives that the percentages represent.

In response to questions regarding the wellness initiative, Commissioner Voss provided that the IID is looking at the experiences of other states, but that any activity implemented will need to have measurable results.

The SHIIP program was used extensively in providing assistance with enrollment in Medicare Part D, and Iowa had the second highest enrollment in the program.

Commissioner Voss agreed to provide information regarding the effect of mental health parity on premiums.

Commissioner Voss agreed to provide a list of the medical services to which the external review applies and noted that dental services are not included.

In response to a question, Commissioner Voss agreed to provide a spreadsheet demonstrating the portion of the market share that each of the individual, small group, and large group markets represents.

Senator Bolkcom stated that it would help to know how much money is involved in the health care system. He noted that during a 2006 interim regarding mental health, a document was provided showing the various sources of funding for the system that was very helpful.

Dr. Carlyle queried about the underinsured and Commissioner Voss agreed to provide information regarding this subject.

III. Health Care Landscape in Iowa — Public Programs — Department of Human Services.

Director Concannon provided information regarding public health care programs under the purview of DHS.

Health Insurance Provided to Children. Director Concannon referred to a document that demonstrated that various instruments rank the state of Iowa at the top with regard to providing health insurance to children. The instruments include the latest census report which showed Iowa's overall insured rate for everyone, not just children, to be 90.9 percent; a 2003 Report of the Health Resources and Services Administration of the United States Department of Health and Human Services, which ranked Iowa fourth lowest in the rate of uninsured children next to Vermont, North Dakota, and Rhode Island; and an Annie E. Casey Foundation survey showing Iowa ranking eighth with 7 percent of children under the age of 18 not covered by insurance.

Medicaid. Director Concannon provided an introduction to the Medicaid program (sometimes referred to as Title XIX because it is Title XIX of the federal Social Security Act). Medicaid is a payor of health care services, not a provider. Medicaid is also the payor of last resort. Medicaid is a state/federal partnership under which the federal government provides federal matching funds for medically necessary health care services and long-term care services. Director Concannon emphasized that in order to be eligible for Medicaid, an individual must both meet income requirements and fit into a category such as children, the frail elderly, persons with disabilities, pregnant women, and very low-income parents. This leaves many individuals, including low-

income, single, childless adults without coverage. Additionally, many parents of children who are eligible for Medicaid are not themselves eligible because the income eligibility level for parents is lower than that for their children. However, states do have the flexibility to determine income eligibility requirements. Director Concannon noted that two-thirds of Iowa's uninsured children are eligible for Medicaid or the state children's health insurance program, hawk-i, the University of Iowa recently completed a study on the barriers to enrollment, and DHS is in the process of adjusting to overcome these barriers. The Medicaid program is administered by the Iowa Medicaid Enterprise which is composed of nine performance-based contractors with the goal of making Iowa Medicaid a well-run managed care organization.

Of the approximately 445,000 Medicaid enrollees, 52 percent are children, 75 percent are adults and children, and 25 percent are the elderly and disabled. However, even though children make up more than half of the number of enrollees, they account for only 17 percent of the expenditures, while the elderly and disabled who make up about one-fourth of the enrollees account for 73 percent of expenditures. The Medicaid program also covers approximately 41,930 women who receive family planning services and prescriptions under a family planning waiver. If the costs of nursing home and home care are eliminated, the average cost per enrollee is comparable to the average insured with private insurance. Nationally, the cost per person in Medicaid is lower than private health insurance.

Director Concannon noted that the Medicare program sets a series of rates for reimbursement of health care services and equipment. Iowa has historically been efficient in providing health care so the state is close to 50th in reimbursement rates. States generally base Medicaid rates on the rates the Medicare program sets. However, in some cases Iowa has set reimbursement even below Medicare rates. In the past, the state has not reduced eligibility as a cost-savings measure, but in turn has not been able to dramatically increase provider rates. The Medicaid program has a panel of 36,000 dedicated providers including all 116 of Iowa's hospitals, over 9,000 physician providers, and providers of medical equipment, pharmacies, and others. Of the 116 hospitals, over 80 are critical access hospitals which receive 100 percent of their costs as reimbursement, thereby not resulting in any cost shifting. With regard to long-term care, Iowa has the highest rate of private pay nursing home residents, but also has the highest number of nursing home residents in the United States. Medicaid covers nursing home care, intermediate care facilities for persons per capita with mental retardation, other congregate settings and home- and community-based services. The department has worked to expand home- and community-based services under Medicaid waivers to allow individuals to remain in their homes and thereby delay much more expensive institutional care.

IowaCare. IowaCare is a program that was implemented in 2005 under a federal Medicaid waiver. The program was structured to salvage the projected elimination of federal revenue in the amount of $65 million by utilizing state- or public-only funds used to provide care to indigent persons as a match for federal funds, while also providing limited health care coverage to low-income individuals, 19-64 years of age, and under 200 percent of the federal poverty level who were not otherwise eligible for Medicaid. The IowaCare program provides a much more limited benefit package than Medicaid and has a provider network limited to Broadlawns Medical Center in Des Moines, the University of Iowa Hospitals and Clinics in Iowa City, and the four state mental health institutes for inpatient psychiatric care. Approximately 22,153 individuals will be IowaCare

members in any given month in FY 2007-2008. In response to a question regarding expansion of IowaCare to other hospitals in the state, Director Concannon noted that the remaining hospitals in the state could provide only approximately $2.5 million in matching state funds which is a very small amount. In response to a question regarding whether IowaCare has a rich enough benefit package to utilize the program for expansion to more adults, Director Concannon emphasized that IowaCare has a very limited benefit package as well as a limited number of providers.

hawk-i. The hawk-i progam is Iowa's State Children's Health Insurance Progam (SCHIP), sometimes referred to as Title XXI because it is Title XXI of the federal Social Security Act). In Iowa, the program is comprised of both a Medicaid expansion program component and a stand-alone SCHIP program. In conjunction with Medicaid, hawk-i covers children zero through 19 years of age up to 200 percent of the federal poverty level. Unlike Medicaid, hawk-i is not an entitlement. The federal government provides a set amount of funding for a state match. The federal match under hawk-i is 73 percent compared with the state match for Medicaid which is 61.98 percent.

Expanded Coverage for FY 2007-2008, Projections for Expanding Medicaid and hawk-i to Cover Additional Children and Parents, Medicaid Waivers. Director Concannon noted that additional funding appropriated for FY 2007-2008 will allow coverage of an additional 10,000 children under the Medicaid and hawk-i programs and an additional 6,500 parents under the Medicaid program through an increase in the earned income disregard. Director Concannon referred to various documents that provide projected costs for utilizing the Medicaid and hawk-i programs to provide health care coverage to additional Iowa children and parents. Medicaid Director Gene Gessow clarified that in arriving at the projections, a cost per individual of $1,900 was assumed, even though actual costs per person vary and the majority of costs are attributable to only a small percentage of individuals. Director Concannon also provided documents with estimates of the number of uninsured children and adults in 2008 and information regarding Medicaid waiver services.

IV. Health Care Landscape in Iowa — Providing a Health Care Safety Net.

A. Department of Public Health.

Role of Department of Public Health (DPH). Director Newton provided information regarding the role of Iowa's public health system. He noted that the public health system utilizes population-based science to make decisions that look at the entire population, and that while DPH does provide some direct services, the role of DPH focuses mainly on providing capacity building, funding, and technical assistance. Director Newton reviewed a document that provided information regarding some of the direct service programs that DPH provides including child health through Title V child health centers, family planning through Title X funding, oral health including the I-Smile dental home initiative and the school-based sealant program, home care aide services, and local public health services. In response to a request, Director Newton will provide information regarding the number of children served at the Title V child health centers.

Challenges. Director Newton reported that one challenge to the public health system is the prevalence of chronic disease. Forty-five percent of Americans have at least one chronic disease and treatment of chronic disease accounts for $3 out of every $4 spent on health care, totaling $1.4 trillion, annually. In Iowa, 60 percent of Iowans are obese, with a cost to Iowans of $783

million, annually. Annual Medicaid costs in Iowa attributable to obesity were estimated by the Centers for Disease Control and Prevention to be $198 million.

Innovations. The DPH has initiated innovative approaches to address public health challenges. The office of healthy communities was instituted by former Director of Public Health Mary Hansen to consult with communities to make lasting changes to provide for healthy lifestyles. The Harkin Wellness Grants have been used to support 28 communities in efforts to enable people to adopt healthy lifestyles. Director Newton provided the example of George, Iowa, which built a walking path adjacent to a nursing facility to provide access to its residents. Iowans Fit for Life is Iowa's state plan for physical activity and nutrition. The Healthy Children's Task Force is a collaborative effort between DPH and the Department of Education to reach out to children. A number of members raised concerns about efforts to target childhood obesity. Director Newton noted that the Harkin grant to address childhood obesity will terminate as of August, 2007. He also noted that DPH works with other agencies and organizations to develop recreational opportunities in communities including bike trails and bike lanes.

B. Iowa Collaborative Safety Net Provider Network.

Mr. Ted Boesen, Executive Director, Iowa/Nebraska Primary Care Association, provided an overview of the Iowa Collaborative Safety Net Provider Network which, in 2005, when the network was initiated, was comprised of rural health clinics, free clinics, and community health centers, but grew in 2007 to also include maternal and child health centers, local boards of health that provide direct services, family planning network agencies, and child health specialty clinics. The 2007 Iowa Acts, chapter 218 (H.F. 909), outlined a vision for the network "to assist patients in determining an appropriate medical home". The legislation also directed that the network oversee initiatives including pharmacy, specialty care, and primary care provider recruitment initiatives. Additionally, the network is continuing to gather bi-annual data from safety net providers to compile in biannual reports, is exploring care coordination software, and has developed communications and advocacy mechanisms. Even though funding was not appropriated by the General Assembly for FY 2007-2008 for recruitment efforts, the network is continuing to work with DPH, the University of Iowa Colleges of Dentistry, Medicine, and Nursing, and other health professional programs to explore cooperative recruitment efforts. These efforts include working with all levels of practitioners to provide greater access to health care. Following a query, it was determined that the direct care worker organization might have information regarding how many direct care workers are uninsured or underinsured. Executive Director Boesen noted that individuals accessing the provider network are given information regarding Medicaid, hawk-i, and other appropriate programs.

V. Summarization of Rebalancing Health Care in the Heartland Forum.

Dr. James A. Merchant, Dean, College of Public Health, University of Iowa, provided a summary of the information presented at the Rebalancing Health Care in the Heartland Forum held on June 19, 2007, and sponsored in part by the University of Iowa. He noted that the sponsors planned to hold the meeting in June in order to assist the General Assembly in its work on health care. The forum was the second meeting in a three-part series with the last meeting scheduled to be held in late

2007, and focus on national health care priorities. He noted that Iowa had recently been found in a Commonwealth Fund Study to be second in state ranking on overall health system performance.

Lt. Governor Patty Judge opened the forum and announced the development of a Commission on Wellness and Healthy Living to promote healthier lifestyles for Iowans. This Commission includes five members, one for each congressional district. The Commission will hold town hall meetings throughout the state to allow Iowans to provide input.

The keynote speaker for the forum, Dr. Steven A. Schroeder, provided an overview of the United States health care system, discussing health status, costs, access, and quality. Jon Kingsdale, Executive Director, Commonwealth Health Insurance Connector Authority, discussed Massachusetts health reform. He noted that the process of reforming the system took a number of years and required grassroots coalition building and a consensus building, nonaccusatory approach. The challenges ahead for Massachusetts include providing sufficient outreach and education to increase enrollment, refining the health coverage provided to make the program sustainable, enforcing near universal participation, and bending the trend in health care costs. The lessons learned were that health care reform takes time, reform must be developed through consensus and not "demonizing" any entity, and to be sustainable the system must consider the "golden triangle" of eligibility, medical costs, and coverage.

Mr. Ron Harr, Senior Vice President, Government Programs for Blue Cross Blue Shield of Tennessee, provided information regarding the Cover Tennessee program. The program was initiated after the failure of the TennCare program which resulted in 200,000 individuals losing coverage. The program includes CoverTN which is a limited benefit plan for the working uninsured; CoverKids, which is a SCHIP expansion plan that also includes pregnant women; and AccessTN, which is a high-risk pool. One of the lessons learned in Tennessee was the need to do research before implementing a program.

Dr. Bruce Goldberg, Director, Oregon Department of Human Services, discussed the Oregon plan which aimed at ensuring access to affordable health care for all Oregonians. The principles of the system are universal access to a basic level of health care; that society is responsible for financing care for the poor; there must be a public process for deciding the basic level of care; effective care is encouraged and overtreatment is discouraged; and funding must be explicit and economically sustainable. Some of the lessons learned in Oregon are that solutions must be system-wide, i.e. publicly and privately financed systems exist as a piece of a larger health care system; explicitly allocating resources is necessary; a public process is essential; attention must be paid to equity and shared responsibility among providers, participants, and financers; and the system must be sustainable and focus on outcomes.

The Iowa panel, moderated by Dr. Merchant, and consisting of Senator Hatch and Senator James Seymour, Representatives Foege and Upmeyer, and Mr. John Hedgecoth, Office of the Governor, noted the need for transparency and consensus in reforming the health care system in Iowa. Iowa has a very good system of health care but it can be improved. Iowa has a real opportunity to provide leadership to the nation in the area of health care reform.

VI. Panel Discussion Regarding the Gaps in Quality, Accessibility, and Affordability.

Directors Concannon and Newton, Commissioner Voss, and Dr. Merchant participated in a discussion regarding the gaps in the health care system. The panel discussed how to address the issue of young adults who do not value health care coverage as a priority. Director Newton noted that the average uninsured person in Massachusetts is a 37-year-old male. The panel also discussed the fact that of the uninsured children in Iowa, many are eligible for but not enrolled in existing programs such as Medicaid and hawk-i. Additionally, about 5,000 of the uninsured adults in Iowa are parents of children enrolled in Medicaid or hawk-i. The panel discussed the need for accurate data and it was noted that Massachusetts instituted a requirement for an annual survey to determine the number of uninsured. In collecting data, the definitions of terms such as "uninsured" and "underinsured" must be clear. The panel also discussed the issue of chronic disease, the fact that seasonal and part-time employment add to the problem of reaching the uninsured, and the problem with reaching adults who are childless.

VII. Health Care Data Research Advisory Council.

Co-chairperson Hatch noted that the legislation creating the Commission also created a Health Care Data Research Advisory Council to assist the Commission in its work. He suggested that there are three specific sets of data that the Commission needs to move forward: a literature review to identify health care reform efforts that might be applicable to Iowa, interviews of stakeholders to identify problems with the health care system and recommendations for change, and a survey of Iowans to determine the true health care landscape in Iowa.

Senator Behn asked that the issue to be considered should not be a determination of how many lack health insurance, but how many lack health care. Ms. Kuhle asked that data collection focus specifically on Iowa rather than national data. The Commission determined that if members have questions or suggestions to share with the Advisory Council, they initially be submitted to Legislative Services Agency staff for subsequent submission to the Advisory Council. Dr. Carlyle noted the importance of addressing health care costs and the role of chronic disease management in reducing costs. Representative Upmeyer suggested that with the short time frame for completion of the Commission's work, it would be important to remain focused. She suggested that organizations such as the National Conference of State Legislatures and others would be good sources of information for the literature review.

VIII. Motions.

A. Motion 1.

Senator Bolkcom moved the following list of items as a motion and Representative Smith seconded the motion:

1. That the Commission approves assigning the role of coordinator of the Health Care Data Research Advisory Council to the University of Iowa College of Public Health under the direction of Dr. Merchant.

2. That the Health Care Data Research Advisory Council deliver to the Commission at the October meeting the results of a comprehensive literature review on health care and relevant subject matter in Iowa and the nation.

3. That the Health Care Data Research Advisory Council conduct extensive interviews with major health care stakeholders on the condition of health care in Iowa and the nation and suggested solutions, and report to the Commission the accumulated narrative of the results at the October meeting.

4. That the Health Care Data Research Advisory Council assist in preparing an extensive survey of Iowans on health care issues.

Senator McKibben asked to either defer on the motion or, in the alternative, to have the approval of the co-chairpersons that before any activities included in the motion are conducted, that the Commission will be presented with a budget for the activities. Co-chairperson Hatch agreed that a budget would be presented at the next meeting of the Commission. The motion was approved on a voice vote.

B. Motion 2.

Senator Bolkcom moved and Senator Ragan seconded a motion to approve giving the co-chairpersons the authority to consult with legislative leaders in hiring a consultant to conduct a survey of Iowans to determine, at a minimum, the following: Who are the uninsured; who are the underinsured; Iowans' level of satisfaction with insurance coverage; and the demographics of Iowans' health care. The motion was approved on a voice vote.

C. Motion 3.

Senator Bolkcom moved and Representative Smith seconded a motion that the Commission authorize the co-chairpersons to negotiate with appropriate consultants to facilitate future Commission meetings. It was suggested that NCSL might provide such technical assistance at no cost other than travel, accommodations, and such essential costs. Senator Bolkcom noted that utilizing a facilitator would allow all members, including the co-chairpersons, to participate equally. Senator McKibben concurred that utilizing NCSL would assist the Commission in focusing, that costs such as travel would be minimal, and that it would be a good idea to have a facilitator. The motion was approved by a voice vote.

IX. Discussion.

Director Newton suggested that he would provide a proposal at the next Commission meeting regarding the long-term care workforce review.

Co-Chairperson Hatch reiterated that former Governors Branstad and Vilsack would be holding public hearings during the month of September on health care reform in three locations,

Davenport, Indianola, and Council Bluffs, and that a caucus staff work group would coordinate this effort.

The schedule for future meetings was discussed and the Commission agreed to switch the locations of the July and August meetings and thereby hold the July meeting in Oskaloosa and the August meeting in Mason City.

X. Materials Filed With the Legislative Services Agency.

The following materials listed were distributed at or in connection with the meeting and are filed with the Legislative Services Agency. The materials may be accessed from the <Additional Information> link on the Commission's internet page:

http://www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=208

- Letter to Members
- Legislative Commission on Affordable Health Care Plans for Small Businesses and Families Membership
- Legislative Commission on Affordable Health Care Plans for Small Businesses and Families Tentative Meetings Dates and Locations
- Legislative Commission on Affordable Health Care Plans for Small Businesses and Families Tentative Agenda
- Rebalancing Health Care in the Heartland Meeting Agenda
- Rebalancing Health Care in the Heartland Reception Invitation
- Legislative Commission on Affordable Health Care Plans for Small Businesses and Families Charge
- Legislative Commission on Affordable Health Care Plans for Small Businesses and Families Legislation
- Guidelines for Interim Study Committees
- Adopted Rules for the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families
- Proposed Motions

From the Division of Insurance Documents

- State Efforts
- Iowa Health Insurance Primer - Dec 2006
- Affordability of Health Insurance for the Uninsured
- State of the States - Academy Health
- State Comparison of Health Insurance Market
- Small Group Health Insurance Survey

- Health Insurance Mandates in the States 2007
- Employer-Sponsored Health Insurance
- Maine
- Massachusetts
- Single-Payer in Connecticut
- Illinois
- Public Role in Financing Health Insurance
- Small Business Premiums
- Public Entities Health Insurance Costs
- Consumer-Driven Health Insurance
- Customer Health Care
- Healthcare - National vs. State Leadership
- Impact of Mandates on Premium Cost
- Insurance Division Presentation

From the Department of Human Services Documents
- Index of Documents Presented by DHS
- Documents Presented by DHS

From the Department of Public Health Documents
- Iowa Collaborative Safety Net Provider Network - Ted Boesen
- HRSA Planning Grant - Striving to Expand Access to Affordable Health Insurance
- Iowa's Public Health System Chart
- Public Health Safety Net Programs
- Iowa's Public Health Safety Net

Additional Documents
- CSG Health Care Reform
- Governing June 2007 "Gimme Coverage"
- Covering America - Real Remedies for the Uninsured
- Websites With Additional Information

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