Legislative Services Agency

MINUTES

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

August 15, 2007 Third Meeting

MEMBERS PRESENT:

Senator Jack Hatch, Co-chairperson
Senator Jerry Behn
Senator Joe Bolkcom
Senator Larry McKibben
Senator Amanda Ragan
Ms. Karen Hanson for John Aschenbrenner
Ms. Amy DeBruin
Dr. David Carlyle
Ms. Barb Kniff
Dr. Timothy Kresowik
Ms. Julie Kuhle
Mr. Charlie Wishman for Jan Laue
Mr. Jay Christensen for Kimberly Russel
Ms. Patsy Shors

Representative Ro Foege, Co-chairperson
Representative Clarence Hoffman
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
Ms. Barb Blough for Dr. Steven Fuller
Mr. Greg Anliker for John McCalley, Director, Department of Elder Affairs
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. Workforce Review Proposal.

III. ABI Health Care Summit Presentation.

IV. Health Insurance Coverage in Iowa: A Tale of Six Reports Presentation by Dr. Pete Damiano.

V. Guiding Principles.

VI. Focused Workgroup Discussions.

VII. Future Meetings.

VIII. Materials Filed With the Legislative Services Agency.

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

I. Procedural Business.

Call to order. Co-chairperson Hatch called the third meeting of the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families (the Commission) to order at 9:10 a.m. on August 15, 2007, in Reunion Hall, Music Man Square, 309 S. Pennsylvania Avenue, Mason City, Iowa.

Approval of Minutes, Welcome, and Review of Agenda. The minutes of the July 18, 2007, meeting were approved as distributed. Local Representative Bill Schickel welcomed the Commission to Mason City and also noted that Representative Upmeyer, who is a member of the Commission, is from the area. Co-chairperson Hatch stated that the Commission would be presented with an update on the public hearings, would review and vote on several motions, would review the guiding principles for the Commission, would have two presentations, and would then break into workgroups.

Public Hearings. The public hearings will take place from 6:00-8:00 p.m. on September 4, 2007 (Council Bluffs), September 26, 2007 (Indianola), and September 27, 2007 (Bettendorf). Those wishing to provide testimony may sign up on-site beginning at 5:30 p.m., at the respective locations. Former Governors Terry Branstad and Thomas Vilsack, the co-hosts of the public hearings, will fly together to Council Bluffs. The Legislative Services Agency (LSA) will provide a summary of each public hearing. The co-chairpersons will also ask former Governors Branstad and Vilsack to report the recommendations presented at the public hearings to the Commission in October. Senator Bolkcom suggested that as much time as possible should be devoted to hearing from those members of the public who attend and want to testify. Commissioner Voss noted that many times people just need to vent, and that it helps to have something to respond to. Co-chairperson Foege suggested that any legislators or members of the Commission who attend should be placed at a table in front of the public seating area.

Motions Regarding Membership. Co-chairperson Hatch presented a motion to accept the resignation from the Commission of Ms. Russel, the representative of the Iowa Hospital Association. Ms. Russel submitted a letter of resignation due to schedule conflicts.

Co-chairperson Hatch also presented a motion to request that the Legislative Council approve the status of Dr. Fuller as a voting member.

The motions were unanimously approved by the Commission on a voice vote.

Update on Data Collection and the Blog. Ms. Ann Ver Heul, LSA Legal Services Division, noted that staff is collecting materials submitted by Commission members to provide information to the members. The materials collected will be categorized and made available on the Commission's website.

Ms. Ver Heul also stated that the Commission's blog is accepting submissions and the submissions are being posted to the Commission's website. A new question will be posted prior to the next Commission meeting.

Iowa Caregivers Association Distribution of Materials. Mr. John Hale, Policy Director, Iowa Caregivers Association, distributed a DVD entitled "Real People, Real Stories, The Uninsured and the Underinsured in Iowa" along with additional materials from the Iowa Caregivers Association. Mr. Hale noted that many of those who provide health and long-term care services do not have

health care coverage of their own and this results in a large amount of turnover and lack of the provision of optimal care to consumers.

Adjournment. The meeting was adjourned at 3:45 p.m.

II. Workforce Review Proposal.

Overview. Mr. Newton, Director of Public Health, introduced Ms. Julie McMahon, Director, Division of Health Promotion and Chronic Disease Prevention, to present a proposal for a review of the health and long-term care workforce.

Ms. McMahon stated that 2007 Iowa Acts, H.F. 909, § 110, directed the Iowa Department of Public Health (IDPH), in collaboration with the Department of Human Services (DHS), the Department of Inspections and Appeals, the Department of Workforce Development, and other state agencies involved with relevant health care and workforce issues, to conduct a comprehensive review of Iowa's health and long-term care workforce. The directive required raising public awareness of the workforce shortage, a description of the current workforce, a projection of the workforce necessary to provide care during the next 25 years, and construction of a workforce model. Ms. McMahon described the activities proposed to comply with the directive including utilizing quick read communications, press releases, press conferences, and other media strategies to raise public awareness; conducting a one-day summit to gather input on the areas of greatest challenge and proposed solutions regarding the current workforce; conducting a literature review and identifying, reviewing, and analyzing existing data to provide a description of the current workforce; meeting with key stakeholders to gather insight into current and projected concerns regarding the workforce; using existing staff time and knowledge to review existing workforce recruitment efforts; and providing a report that includes findings limited to the time frame available. Ms. McMahon noted that due to the short time frame and the lack of financial resources, the review would not provide workforce projections for the next 25 years nor would it provide for the workforce modeling. There are sources that could be utilized to develop the projection, but would require additional time and funding. Also, the 25-year projection might need to be shortened due to the variables that make a 25-year projection difficult. A workforce model would also require establishment of a work plan and additional funding.

Discussion. The estimated cost to complete the proposal is $30,000 and the department would reassign tasks to make a .5 FTE employee available to the project.

Dr. Carlyle stated that even though the 25-year projection might be difficult to determine, it is important to complete a long-range projection due to the time necessary to train various professionals. Mr. Anliker inquired if it is the lack of funding or lack of time that is prohibiting the development of the model. Ms. McMahon replied that it is both. The Commission members then discussed with Ms. McMahon what could be delivered by January 15. Ms. McMahon noted that all of the directives would be completed with the exception of the 25-year projection and the model. She noted that there is data available regarding some professional segments of the workforce, but that data regarding other segments is not available. Senator Bolkcom suggested that the report include short-term goals as well as long-term goals. Representative Upmeyer suggested that each of the health care professional boards collects some data and that this might be a source of

information. The members asked that Ms. McMahon provide a preliminary report to the Commission in October.

Approval. The Commission unanimously approved the motion on a voice vote in support of the health and long-term care workforce review proposal and the requisite $30,000 in funding.

III. ABI Health Care Summit Presentation.

Mr. Teeling, representative to the Commission designated by the Association of Business and Industry (ABI), presented an abbreviated version of presentations made to the ABI National Summit meeting in Des Moines on July 25, 2007, focusing on chronic disease management.

Mr. Teeling reviewed information from a presentation entitled "Benefit Design–Aligning Incentives to Engage the Patient and Lower Total Health Care Costs" that provided information regarding the percentage of Americans with chronic diseases; trends in the prevalence of obesity, diabetes, and chronic obstructive pulmonary disease (COPD); the costs associated with chronic diseases and unhealthy behaviors; and benefit designs that provide incentives for healthy lifestyles and behaviors. A second presentation entitled "Employer Investment in Health: An Emerging Strategy for Additional Stakeholders" provided rules for optimizing employee health benefits for a healthier and more productive workforce including: the health of your organization begins with your people; to realize total value, you must understand total cost; higher costs don't always mean higher value; health begins and ends with the individual; avoid barriers to effective treatment; carrots are valued over sticks; and total value demands total teamwork. A case study at Pitney Bowes utilizing these rules and utilizing predictive modeling demonstrated the value of chronic disease management. A third presentation entitled "HealthMapRx–Using Benefit Design and Collaborative Practices" addressed diabetes management in a case study for the city of Asheville, North Carolina. The program began by soliciting physicians to help design the model and support the process; soliciting and credentialing pharmacists to engage patients; developing federal Health Insurance Portability and Accountability Act (HIPAA)-compliant tools for data collection, reporting, and publication; collaborating with employers to facilitate implementation; aligning patient education services through community health educators; and setting an agreeable fee schedule for pharmacists providing services under the model.

After six years the results are positive regarding medical costs, patient participation, sick leave usage, and clinical indicators. The results indicate that pharmacists that have the opportunity to assist with patient care have made a difference, physicians with patients in the program recognized the positive impact on care, collaboration plus innovation leads to reduced health care costs, and employers benefit by lowering or eliminating barriers to care.

IV. Health Insurance Coverage in Iowa: A Tale of Six Reports Presentation by Dr. Damiano.

Overview. Dr. Damiano presented information compiled from six reports regarding Iowa health insurance coverage for children, adults, and through businesses; trends in coverage; the impact of coverage-related issues; and the willingness to change. He also noted the gaps in the knowledge base. Dr. Damiano emphasized that due to the varying methodologies used in the reports, he

might not be able to answer specific questions from Commission members, but could find answers after the meeting.

The six reports summarized were: the 2005 Iowa Child and Family Household Health Survey, which provides information about child-coverage issues; the 2005 IDPH Survey of Iowa Consumers, which provides information about adult coverage issues; the 2005 Iowa State Planning Grant which provides information about adult issues based on 2005 Iowa survey data and national data; the 2004 "What a Drag It Is" report that provides information about business attitudes about coverage; the 2001 Iowa State Planning Grant based on consumer surveys and focus groups and business surveys; and "Iowan's Talk about Examining Health Care".

Demographics. Dr. Damiano reported that, based on national data, 62 percent of insurance coverage is employer based, 14 percent is Medicare, 5 percent is Medicaid, 9 percent is nongroup, 1 percent is other, and 9 percent of the population is uninsured. Dr. Damiano reviewed a chart demonstrating the public insurance programs for children 0-18 years of age in Iowa with a portion being covered under Medicaid, a portion being covered under Medicaid expansion through the State Children's Health Insurance Program (SCHIP), and the remainder being covered under the Iowa SCHIP program hawk-i.

In Iowa, 9 percent of people in all age categories are uninsured. Three percent of Iowa children are uninsured, 12 percent of adults 19-64 years of age are uninsured and 19 percent of people 19-24 years of age are uninsured. By race, whites make up 9 percent of the uninsured in Iowa, blacks are 12 percent of the uninsured, and the Hispanic/Latino population makes up 22 percent of the uninsured. By gender, 10 percent of men and 8 percent of women are uninsured.

By marital status, 7 percent of married individuals, 11 percent of the unmarried, and 14 percent of the divorced/separated are uninsured.

By income, 37 percent of those with incomes under $20,000, 23 percent of those with incomes between $20,000 and $30,000, and 20 percent of those with incomes greater than $50,000 are uninsured.

Children. With regard to uninsured children in Iowa, coverage of children improved from 2000 to 2005 with a reduction in the percentage of uninsured children from 6 percent to 3 percent. Four percent of children were uninsured at some point in a year, 25 percent of uninsured children had a parent who was uninsured, and 20 percent were without dental insurance, which was an improvement from 25 percent in the year 2000. The reasons for lack of coverage related to issues of high cost and a lost job and/or benefits. Of the uninsured children in Iowa, three-fourths are eligible for Medicaid or hawk-i. If all children up to 200 percent of the federal poverty level were enrolled in these programs, 99 percent of Iowa's children would have health insurance coverage, with 180,000 being enrolled in Medicaid, 15,000 in Medicaid expansion, and 20,000 in hawk-i. From 2000 to 2005 employer-based insurance for children declined from 83 percent to 72 percent. Additionally, 20 percent of children with private insurance had been on Medicaid at some point in their life and 3 percent had been on hawk-i.

Parents. With regard to parents, the percentage of uninsured parents remained stagnant at 11 percent between 2000 and 2005. Eighty-three percent of parents have the same insurance coverage as their child and 70 percent of these have insurance through an employer. Ninety

percent of parents reported that health insurance is very important for them and 97 percent reported that health insurance is very important for their children.

Adults. With regard to adults, 81 percent of uninsured adults were employed. Two-thirds of uninsured adults were without insurance for more than one year and 20 percent of the uninsured adults were without coverage for 10 years or more. Of the uninsured adults, three-fourths reported being in good or excellent health, three-fourths never turned down a job with coverage one-fourth declined coverage from work, and of those who declined coverage one-third thought they would have to pay $200 or more per month for insurance.

Employer Coverage. With regard to employer coverage in Iowa, 54 percent of employers offer health insurance. The percentage offering insurance coverage varies by number of employees with larger employers offering coverage more often than small employers. Fifty percent of employers pay the entire premium, and employees who are uninsured are more likely to be employees with low-wage jobs.

Employers in Iowa offer coverage to attract/retain employees, to keep employees healthy, to be good corporate citizens, and because employees expect coverage.

Children — Public and Private Coverage. In comparing uninsured children with privately and publicly insured children, the uninsured are less likely to have a regular source of care such as a personal doctor or nurse, they have fewer doctor visits, they are much more likely to have an unmet medical need (17 percent versus 1 percent), they are less able to get sick care, they are more likely to have had an emergency room visit, they are less likely to have had a preventive visit in the past year (with those covered by Medicaid or hawk-i being the most likely to have such a visit), and their parents are most worried about paying for their child's care. Uninsured children are least likely to be rated in excellent health and are least likely to have a special health care need (with those on Medicaid or hawk-i being most likely to have a special health care need). Parents of uninsured children are most worried about paying for their child's care and feel it is slightly less important for a child to have insurance. Of those parents with insurance for their child, 30 percent had a problem paying for a service and 10 percent rated their insurance as fair or poor at meeting their needs. Those with Medicaid or hawk-i were more likely to rate the insurance as excellent compared with those with private coverage. Overall, those with coverage through a public insurance program rate their coverage better than those with private coverage and these programs focus on preventive care and keeping a person healthy.

Lack of Coverage Effects. For adults, not having coverage resulted in one-third putting off a visit to the doctor, 55 percent delaying care, one-half reducing their use of their plans, one-fourth changing plans, one-fourth not scheduling suggested tests, one-fourth not filling a suggested prescription, one-fourth staying in a job they didn't like, and one-fourth having coverage affect a retirement decision. Of the covered adults, 60 percent report their costs are increasing, they fear losing coverage, and that they are making sacrifices. Eighty percent of the uninsured adults would benefit from coverage.

Employers are impacted by providing coverage that costs an average of $337 per month per employee. Although 92 percent of companies are being hurt by health insurance costs, many employers are reluctant to transfer costs to employees. Sixty percent of employers report that their

employees are more productive if they have coverage, 75 percent will try to absorb the cost of coverage, and one-fourth will increase contributions or use contractors.

Rising Costs. In the future to reduce costs for adult coverage one-half will choose a plan with higher deductibles, one-half will choose a plan with higher co-pays, two-thirds will use more nurse practitioners and physician assistants, and 40 percent will reduce the number of doctor visits. With regard to a health security/social security-like plan, 74 percent thought it was a good idea, two-thirds said it would benefit them, 60 percent supported it, and 16 percent opposed it. The average amount an uninsured adult is willing to pay for coverage is $82 per month, with a median amount of $50.

Employer Coverage. Of the employers not currently covering employees one-third are willing to contribute nothing, one-third are willing to contribute less than $100, and one-third are willing to contribute more or are unsure. Fifty percent of employers not currently providing coverage are willing to participate in a subsidized plan, 30 percent are not, and 20 percent reported that it depends on the subsidy. Sixty-two percent of employers reported that state funds should be used to help low-wage employees.

Employer Subsidy Options. With regard to possibilities to assist employers, a tax credit could be offered to employers with less than 25 employees. It is estimated that 150,000 employees would be eligible, 120,000 of whom are now uninsured; that 40,000 would agree to participate and 32,000 would be new insureds; and the cost would be approximately $17 million. For a subsidized insurance product, the state could subsidize the highest-cost employees with reinsurance at a cost of $3 million for 11,000 people. Other options are pooling with state employees, which is less viable in Iowa because of the low degree of competition, or combinations of the foregoing strategies.

Discussion. Dr. Damiano asked Commission members to indicate whether they perceived any gaps in the data. Dr. Kresowik asked what percentage of uninsured adults are eligible for but are not enrolled in public programs. Dr. Damiano referred to the information provided by DHS at the first meeting and also asked Mr. Gene Gessow, Medicaid Director, to respond. Mr. Gessow responded that the income eligibility level for adults is only 27-28 percent of the federal poverty level, so very few adults are covered or are eligible for coverage in public programs.

Ms. Kuhle asked how much could be saved if only a basic level of care is provided to everyone in public programs such as Medicaid and if that savings could be redistributed for the funding of coverage for everyone. Dr. Damiano replied that they aren't the same pots of money and that the state might have savings in Medicaid, but the money cannot be moved around that easily.

Mr. Sporer asked how much of the insurance market in Iowa is subject to the federal Employee Retirement Income Security Act (ERISA). Commissioner Voss responded that about 50 percent is publicly funded, 25 percent is self-funded (subject to ERISA), and 25 percent is not subject to ERISA.

The question was raised about what is meant by "underinsured". Dr. Damiano stated that the definition used in the reports he summarized does not seem appropriate for the work of the Commission. He suggested that who is "underinsured" is a relative term and is a determination of the ability to pay for what a person needs.

Dr. Carlyle asked about the availability of insurance through an employer. Dr. Damiano suggested that about 90 percent of employees have access to insurance. He noted that the part of HIPAA that is forgotten is that employers are required to offer coverage, but not necessarily to pay for coverage.

Senator Bolkcom asked what can be done to find the children who are eligible for but not enrolled in Medicaid or SCHIP (hawk-i). Dr. Damiano stated that good outreach is the answer. He suggested that some people will not sign up because they perceive it as welfare. He also suggested that there are systemic changes that could be made to make the process easier. Senator Bolkcom asked for a sense of what would need to be budgeted to get to these children. Dr. Damiano agreed to present estimates for covering these children. Dr. Carlyle asked if the percentage considered to be total coverage of children in Iowa is 97 percent or 100 percent. Dr. Damiano responded that there are still things that can be done to get closer to 100 percent, but that it is like the unemployment rate in that there is a static rate of unemployment and there will always be some children who are not covered.

Dr. Kresowik asked that a price be teased out regarding the pharmacy benefit portion of coverage and noted that part of the question of underinsurance is related to the pharmacy benefit. Dr. Damiano stated that he would speak with the pharmacy experts about this and also stated that pharmacy is no longer a "side" benefit.

Senator Bolkcom asked what the total expenditures are for health care in Iowa and Dr. Damiano stated that the number was not included in the reports, but he could find it.

Ms. Swisher expressed interest in the rural versus urban differences relating to health care coverage and care.

Mr. Anliker asked if there is an average health expenditure based on age. Dr. Damiano noted that coverage for kids is relatively inexpensive and that Massachusetts has offered low-cost policies for the 19-24 year old demographic and is being flooded with applications. Mr. Anliker noted that if people are not covered and show up in the emergency room, everyone pays for it. Dr. Damiano noted that 70 percent of emergency room visits could be seen in physicians' offices if there were physicians available in the evenings and on weekends, so the question isn't just one of being uninsured but also one of availability of care.

V. Guiding Principles.

Mr. Bruce Feustel, Commission Facilitator, presented a document listing the guiding principles that emerged from the previous Commission meeting. The co-chairpersons explained the guiding principles and the Commission discussed the document presented. Some members noted conflicts between principles, and others did not agree with the details of a particular guiding principle. Others noted that the guiding principles are similar to those presented by other entities working on health care reform. Following discussion and a motion for a roll call vote, the Commission determined that only the broad principles would be put forth for voting and not the description of each principle. Senator Bolkcom moved adoption of the bolded broad principles and Senator Ragan seconded the motion. The motion was adopted unanimously on a voice vote. The motion for a roll call vote was withdrawn.

VI. Focused Workgroup Discussions.

Mr. Feustel directed the Commission members to break into three working groups: providing funding; containing costs and improving quality; and coverage–increasing coverage, enhancing access to care, and promoting wellness and prevention. Each group was provided a list of questions to discuss to determine areas of agreement, areas of disagreement, and gaps in information.

The work groups reported their deliberations to the full Commission as follows:

A. Providing Funding Workgroup.

Questions and responses included:

1. Do we want to involve employers in financing?

   The group agreed that current contributions from employers should be continued, that employers and employees should be involved in the financing, and to investigate a "connecter" concept for small businesses to access health insurance as a pretax benefit for employees using a template with five or six plans. The group disagreed on using new payroll taxes to fund coverage, and on mandates. The group would like more information on ERISA and on the Massachusetts' plan regarding how much employers contribute and who is exempted.

2. Should the revision/expansion of existing public programs be the basis for coverage of the uninsured? Should there be redistribution of funds? Should chronic diseases be covered?

   The group agreed that using public programs as well as private programs would provide efficiencies and cost containment in any expansion. The group did not agree on parental mandates for children's health insurance or on expanding the Medicaid or IowaCare programs for adults and how to pay for it. The group would like additional information on the cost to cover all uninsured children 0-18 years of age and adults 19-24 years of age, the cost of keeping children on their parents' insurance until age 24, and what other states are doing about chronic disease management.

3. Should we pursue enrolling people who are eligible but not currently enrolled in public programs? How do we fund it?

   The group wanted more information on what workplace incentives there are for 19-24 year olds to opt into coverage.

4. Will we seek a shared funding arrangement involving employers, government, and individuals? What kind of arrangement makes sense?

   The group agreed that a three-prong system is needed and to look at pursuing reinsurance.

   The group wanted more information about reinsurance for catastrophic coverage paid for by the state. The group would like information from the National Conference of State Legislatures (NCSL) about other states' best practices.

5. Are we considering special "sin" taxes or general or earmarked tax money as a source of funding?

The group did not agree on the issue, but discussed some sources such as the General Fund of the State versus more sin taxes, gaming revenues, or taxes on pickups.

6. Additional comments.

The group had great interest in the pretax portion of the Massachusetts' plan and in setting up five or six plans for people. They also had interest in and agreed to look at reinsurance and the state covering high-risk populations through a pool. The group wanted more information about how private insurance rates would decrease if the state chose to do the reinsurance pool.

B. Containing Costs and Improving Quality Workgroup.

Questions and responses included:

1. What are the cost drivers?

Quality of life, defensive medicine, an aging population, cost shifting, the number of uninsured, chronic illness, research, standards and regulations, lifestyle, specialization, increased utilization, and fraud.

The group wanted more information from the Dartmouth Atlas and the Commonwealth Fund on these issues and also wanted more information on the overutilization of specialized services.

2. Should we address end-of-life care?

The group agreed that education of consumers and providers regarding choices is important, a single point of entry system would help in informing consumers of options, consumers should have more information about advance directives, and more palliative care should be used. The group wanted more information on palliative care.

3. Should we address rationing or prioritizing of some health care services?

The group agreed that rationing is not the correct term, but to instead discuss the prioritizing of health care services. They agreed that in any prioritization the patient must have choices, that care and coverage must be appropriate and not overutilized, that evidence-based professional standards should be used in the prioritization process, and that consumers should be educated about their options.

4. Can we improve the quality of care and reduce costs?

The group thought that quality could be improved and costs reduced by encouraging prevention and healthy communities, providing the tools to consumers and providers to make the right choices, providing incentives or disincentives for consumers and providers, and by eliminating errors. Pharmaceutical homes can help to increase quality.

The group did not agree on the type of incentives or on self-monitoring of the system.

The group would like more information on medical savings accounts.

5. Should there be standards in reporting on quality of care?

The group determined that it is difficult for consumers to understand data provided and to make comparisons regarding quality of care. Transparency is needed. The degree of cost shifting is hard to determine.

The group did not agree on self-monitoring of the industry.

The group wanted more information on comparison of costs, variance in "costs" versus "charges", the volume of charity care, and the costs/charges of different insurance coverage.

6. Should we address scope of practice issues?

The group agreed that there should be more communication between providers and that electronic health records/banking might be beneficial. The group agreed that an adequate, professional workforce is needed.

The group did not agree to mandating staffing ratios.

The group wanted more information on staffing levels and how they impact the quality of patient care.

7. How do we address administrative costs?

The group agreed that direct consumer marketing might be reduced to decrease administrative costs.

The group wanted more information about what the definition of "administrative costs" is, and the administrative costs at each level of care. Some asked to have information regarding what constitutes nonprofit status and the amount of administrative costs that are attributable to CEO salaries and benefits.

8. Is the certificate of need process working to reduce costs?

The members agreed that a review of the process should take place to determine if the process is working to reduce costs. The group wanted more national data on how other states' certificate of need processes work to reduce costs.

9. What are reasonable reserves/surpluses for hospitals and health insurers?

The group wanted more information about reserves versus surplus and what the law requires.

C. Coverage — Increasing Coverage, Enhancing Access to Care, and Promoting Prevention and Wellness Workgroup.

Questions and responses included:

1. What are the barriers to greater coverage? What are specific barriers for small businesses?

The group agreed that cost is the biggest barrier. Adding coverage adds costs, but preventive care helps quality of life. Preventive measures are key and there is a need to

change health care to prevention rather than intervention. Some people are too proud to accept government coverage. Some people are ambivalent about paying for coverage, such as young adults. Insurance mandates add coverage, but also add cost.

The group wanted more information about options for using incentives or penalties to alter behavior; wanted to ask the insurance commissioner to provide costs for various types of coverage such as mental health, substance abuse, and different tiers of coverage; and wanted more information about the cost-effectiveness of prevention/wellness measures, and what types of savings are possible: productivity, quality of life, etc.

2. Are there priorities in terms of certain groups such as children and pre-Medicare adults?

The group agreed that the real problems are pre-Medicare older adults 55-64 years of age. They need medical care now for medicine and services for chronic disease, and the number of people in this group is expanding. Children are mostly covered. Others that need coverage are the working poor, people working for small businesses, and low-wage employees. Dental coverage is especially important for children, but it is also important for adults, including those covered by Medicare. We should build on the good, existing system in Iowa.

The group wanted more information about pre-Medicare adults and why they are uninsured, how many there are, and the cost to insure them. The group also wanted more information about wellness and what cost savings might be realized; where pockets of uninsured children exist, how best to get them enrolled in programs if they are eligible, and the cost; and why health outcomes in the United States are worse than other countries, taking into account cultural and economic differences.

3. What should a medical home requirement include?

The group agreed that a medical or dental home provides treatment and continuity of care. Access to providers is needed and there should be incentives, such as increased reimbursement, for providers to be a medical home.

The group did not agree on the definition of "medical home".

The group wanted more information on the type of legislation that would facilitate creating medical homes.

D. Committee Discussion of Information Requests.

Following the reports of the individual groups, the Commission members also asked for additional information including:

Reserves and Surpluses. Ms. Shors asked for more information on the reserves versus surplus issue.

Electronic Health Records (EHRs). Dr. Carlyle suggested that EHRs could be helpful, but the cost is prohibitive for small practices. The issue is how to make it affordable. Co-chairperson Hatch noted problems with privacy issues related to EHRs and the federal role in trying to develop

regional groups for EHRs. He also stated that the issue of EHRs is often raised in the context of health care reform. Representative Upmeyer provided information about the Health Information Technology Task Force that has been meeting for over a year. The task force has been looking at information banking and she noted that an organization that is involved in information banking could be brought before the Commission or that she could bring the information from the task force.

Other States Reforms. Ms. Kuhle asked if there are other states that are addressing funding issues. Director Concannon noted that there are elements of the Massachusetts plan that could be used, such as providing plans for employees on a pretax basis and providing reinsurance for high-cost consumers. Commissioner Voss noted that in an earlier study about providing reinsurance for microemployers, those with 2-10 employees, the estimated cost was $3 million.

Cost Containment Effects. Director Newton suggested looking at the relationship between cost containment and the benefits of wellness and prevention. Ms. Kuhle suggested that even if cost containment does not result, incentives for prevention and wellness provide individuals and providers the tools to do the right thing. Senator Ragan mentioned Alegent Health Systems in Omaha which Senator Behn had mentioned in the small group as an example of providing incentives for wellness and prevention. Senator Behn noted that the company has already realized some cost benefit, and Commissioner Voss noted that this may be a long-term proposition.

Existing Iowa Intiatives. Dr. Carlyle suggested as a stopgap measure providing care and medication to persons with diabetes through free clinics. Co-chairperson Hatch noted that the safety net provider network is working on the concept of dispensing pharmaceuticals. Representative Upmeyer stated that there are partnership programs that also provide this stopgap and Dr. Carlyle suggested that there is no unifying way to provide this at present.

Consensus Items. Mr. Feustel asked for clarification that there is consensus on covering pre-Medicare adults, the working poor, and children, including dental coverage.

Chronic Conditions and Long-term Care. Mr. Teeling shared a message from a person with a child with autism who is concerned about what to do when the child becomes an adult. Mr. Teeling asked if this is part of the Commission's mission. Co-chairperson Hatch responded that it is part of the discussion and that there would have to be a decision about how to connect the parts of the system. He recommended that the consumer be put in touch with DHS. Director Concannon stated that Dr. Parks is currently working with workgroups regarding persons with disabilities. Co-chairperson Hatch noted that in addition to persons with disabilities there is the issue of long-term care. He suggested that the insurance commissioner should be provided the tools to act as a consumer advocate, not only in the area of long-term care but also in a broader sense. Ms. Kuhle suggested utilizing the Senior Health Insurance Information Program (SHIIP) on a broader basis to assist people with their insurance questions.

Medical Education. The question was raised regarding whether there is sufficient capacity in medical schools or if capacity would have to be increased. Dr. Damiano noted that even if capacity is increased, the important issues are where the student comes from and where they go afterward to practice. He noted that there are ways to recruit that improve the possibility of retaining the person.

Mr. Feustel noted that even if wellness and prevention do not provide cost savings, there is interest in pursuing them.

VII. Future Meetings.

Co-chairperson Hatch informed members that NCSL would be bringing in three national experts on health care to provide information at the September meeting. Additionally, more information collected by the Health Care Data Research Advisory Council will be presented. By October Co-chairperson Hatch would like the Commission members to start verbalizing the health care plan they want to recommend. Co-chairperson Foege noted that there will also be information to report during the Commission meeting in September from the first public hearing held on September 4, 2007, in Council Bluffs.

VIII. 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 Committee's internet page: http://www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=208.

1. Prevention Priorities Policymakers Guide submitted by Dr. Pete Damiano.
2. Medical Homes submitted by Commissioner Susan Voss.
3. Surveys Summarized by the Advisory Council.
4. 2001 Iowa State Planning Grant - Final Report.
5. 2004 Kinzel Business Study.
6. 2005 Consumer Health.
7. Iowa Health Care Book.
8. 2005 Health Care Survey.
9. Mason City Location for August 15, 2007, Meeting.
10. Background Information from Bruce Feustel, NCSL.
11. Universal Health Care by Laura Tobler, NCSL.
12. Nursing Economics Article, March-April 2007.
13. Single-Payer Health Systems, BMJ (British Medical Journal) July 25, 2007.
14. Universal Coverage in the U.S. - Urban Health, March 2001.
15. Minnesota Medicine Article, Feb. 2007.

16. Information from the ABI Health Care Summit.
17. ABI Health Care Summit, Terry McInnis, MD, MPH.
18. ABI Health Care Summit, Hom Health - Investment Iowa.
19. ABI Health Care Summit, HealthMapRx, John Miall.
20. Except from H.F. 909 re: Health and Long-term Care Workforce Review and Recommendations.
21. Focus Group Assignments.
22. Guiding Principles for the Commission.
23. Iowa Department of Public Health Proposal and Budget for Health and Long-term Care Workforce Review and Recommendations.
24. Health Insurance Coverage in Iowa - A Tale of Six Reports, submitted by Dr. Damiano.
25. Press Release for Public Hearings.
26. Public Hearings Information.
27. Maps to Iowa Western Community College and to Looft Hall.
28. Map to Simpson College, Indianola, IA.
29. Map to Mississippi Bend AEA, Bettendorf, IA.

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