Legislative Services Agency

MINUTES

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

September 19, 2007 — Fourth Meeting

MEMBERS PRESENT:

Senator Jack Hatch, Co-chairperson	Representative Ro Foege, Co-chairperson
Senator Joe Bolkcom	Representative Elesha Gayman (alternate)
Senator Larry McKibben	Representative Dave Heaton (alternate)
Senator Amanda Ragan	Representative Clarence Hoffman
Mr. John Aschenbrenner	Representative David Jacoby
Mr. David Carlyle, M.D.	Representative Mark Smith
Ms. Barb Kniff	Representative Linda Upmeyer
Mr. Timothy Kresowik, M.D.	Mr. Russ Sporer
Ms. Julie Kuhle	Ms. Sarah Swisher
Ms. Jan Laue	Mr. Joe Teeling
Ms. Patsy Shors	Ms. Sharon Treinen

Ex Officio Members:
Mr. Gene Gessow, for Kevin Concannon, Director, Department of Human Services
Mr. Larry Carl for Mr. Steven Fuller, D.D.S.
Mr. 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.

Call to Order. Co-chairperson Foege called the fourth meeting of the Legislative Commission on Affordable Health Care for Small Businesses and Families (the Commission) to order at 9:10 a.m. on September 19, 2007, in the East Room, Carver Pavilion, University of Iowa Hospitals and Clinics, Iowa City, Iowa.

Approval of Minutes, Welcome, and Review of Agenda. The minutes of the August 15, 2007, meeting were approved as distributed. Co-chairperson Foege stated that the goal for the day was to develop concepts that can be operationalized. Co-chairperson Hatch added that the Commission should work to develop broad concepts that could be developed over the next two meetings of the Commission and submitted as recommendations to the General Assembly.

Motion. Co-chairperson Foege presented a motion to formally replace Ms. Kimberly Russel, the representative for the Iowa Hospital Association (IHA) who resigned from the Commission at the August meeting, with Mr. Jay Christensen, the alternate named by the IHA. The motion was moved and seconded, and was unanimously approved on a voice vote.

Public Hearings Update. Members attending the first public hearing on September 4, 2007, in Council Bluffs reported that the public hearing was very instructive and that former Governors Terry Branstad and Tom Vilsack fit the role of co-host well through their interaction with the public and their wealth of knowledge about health care.

Long-term Care Insurance. Commissioner Voss reported that she had submitted her report on Long-term Care Insurance to Governor Chet Culver on September 17, 2007, after a three-month review by the Iowa Insurance Division. The report includes 27 recommendations, some of which are being implemented and some of which require legislation to implement. The 250 page report, along with an executive summary, are available on the internet at the Insurance Division's website.

Electronic Health Records Task Force Meeting. Representative Upmeyer invited members of the Commission to attend the October 1, 2007, meeting of the Electronic Health Records Task Force at the Iowa Foundation for Medical Care in West Des Moines, Iowa, at which health record banking expert, Dr. William A. Yasnoff, will present information. Representative Upmeyer noted that the task force has been working on many options and that banking records might help address the issue of interoperability. Representative Upmeyer will make a presentation regarding electronic health records at the October 17, 2007, meeting of the Commission in Sioux City.

Listening Post Report. Senator Bolkcom reported on the 16 listening posts that were held through Working Families Win, a grassroots organizing campaign sponsored by a number of organizations. There have been a variety of participants and the listening posts have had bipartisan legislative participation. Some of the concepts voiced during the listening posts are the need for a focus on wellness and prevention, coverage including the cost and inadequacy of coverage, the high cost of COBRA coverage, issues with mental health coverage and access to care, insurance pooling, the need for reprioritizing what is covered, such as certain prescription medications, a single payor plan based on Medicare, the need for states to move forward and not wait for the federal government, and regulation of insurance companies.

II. 2007 Iowa Employer Benefits Study.

Mr. David Lind, David P. Lind and Associates, provided information based upon the 2007 Iowa Employer Benefits Study conducted by his firm. The study is the ninth annual study. The response rate for the study is 43.3 percent, with 819 Iowa employers responding. The focus of the study is on trends between the years 2000 and 2007. The findings are comparable to the findings in a national study by the Kaiser Family Foundation. In 2005, the study added smaller employers with 10-19 employees.

The study demonstrates that overall, 92.1 percent of employers in Iowa offer health insurance benefits. The study provides detailed information about average health insurance rate increases; responses of employers to health insurance rate increases including increased employer contributions, raised deductibles, and increased office copays; changes in amounts of deductibles, out-of-pocket amounts, office copays, pharmaceutical copays, monthly premiums, employee contributions; historical costs for annual single and family medical contributions; changes in the percentage of the monthly premium paid by the employer and the employee; the percentage of employers offering health and wellness initiatives; and consumer-driven health plans.

The study does not provide information based upon the average annual wage of an industry, but some industries, such as health care providers, do have higher premiums. The study is based on employers based in Iowa and Iowa employees.

With regard to wellness initiatives, it is easier for larger employers to offer wellness and other initiatives due to having more resources, time, and finances. Also, the self-insured are more likely to implement initiatives because they are the only group in their insurance plan. Opinions vary as to whether health and wellness initiatives save money, but some employers implement these measures because they make sense for the health of employees. Incentives are necessary to have successful wellness efforts.

Ultimately, the issues of chronic disease, health care costs, and information sharing must be addressed. There is sometimes a tension between coverage for single persons and family plans. The survey has not demonstrated a shift in Iowa to outsourcing to reduce health care costs.

III. Preventative Health Hostel.

Ms. Therese Murphy, RN, presented information about the health hostel concept, the primary objective of which is to increase consumer accessibility to routine preventative diagnostic testing, health education, and wellness programs as part of a health maintenance program in a managed care environment. A secondary objective is to establish an on-site computer network of diagnosis-related information and referral to be available upon consumer demand or by physician referral. A third objective is to develop an on-site coordinated ancillary support services network that could work collectively in a holistic approach to facilitate optimal health maintenance or health achievement. The fourth objective is to establish a data bank of information to be utilized to send appropriate health care reminder information.

Ms. Murphy provided background about the development of the concept and the name which comes from the hostels used by travelers. The concept would divide the health care delivery system into one of health and one of illness. The hostel would provide more routine testing, up-to-

date literature and support group linkages, as well as a coordinated ancillary services package. These services would be provided largely by nonphysician professionals. Physicians would then be able to focus on illness and dedicate more time to each patient. A cost analysis has not been done, but this model is proactive, applying the principles of managed care, cost containment, and appropriate allocation of professional resources. There could be potential insurance premium cost savings due to a more appropriate health care delivery system.

IV. Federal Employee Retirement Income Security Act (ERISA).

Mr. Jay E. Sushelsky, Senior Attorney, AARP Foundation Litigation Department, provided information regarding ERISA relative to state health care reform.

Mr. Sushelsky noted that prior to the adoption of ERISA in 1974, states had a long history of involvement in the regulation of health care. In order for states to continue to be involved in health care regulation, they must navigate the "relate to" clause which provides that the provisions of ERISA supersede any and all state laws as they relate to any employee benefit plan. This does not necessarily mean "related to" insurance, so that even if the benefit plan cannot be regulated, the insurer can be regulated. The "savings clause" in ERISA states, in part, that the provisions of the Act are not to be construed to exempt or relieve any person from any law of any state which regulates insurance. Self-funded plans, which are subject to ERISA, are for the most part the product of large employers. Therefore, states have the most effect on regulation of insurance of those who are not self-insured.

A state law is most likely to avoid preemption by the exercise of traditional state police powers in the regulation of health care, if the law is one of general application, or if the law provides for a tax. A state law is most likely preempted if it imposes requirements on plans, deals with plan administration, provides for alternate enforcement mechanisms, or deals with plan structure. A state can regulate insurers and insurance products and not be preempted. If a plan purchases an insurance product, a state may regulate the product but not the plan.

The Maryland Fair Share Act imposed a payroll tax on large employers and authorized a dollar-for-dollar credit against the tax for amounts covered employers spent on health insurance costs. The taxes were collected by the state's secretary of labor and used to support the state Medicaid program. The court held that the Act directly regulated plans because there were no meaningful alternatives. The only rational choice employers had was to meet the minimum spending threshold thereby effectively mandating employers to provide a certain level of benefits. The law was preempted because of its connection to the plans. There have been other preemption challenges based on providing participants the right to assign benefits to any service provider whether or not they are in the network, regulation of pharmacy benefit managers, prompt pay laws, and state medical licensing boards' disciplinary inquiries into a physician's judgment.

Mr. Sushelsky noted that states should not be deterred because many challenges based on preemption fail.

In response to a question by Co-chairperson Hatch concerning an employer who has three employees and whether a state could allow employers to pay a pro rata share to provide health care coverage to the employee, Mr. Sushelsky noted that if this is voluntary on the part of employers, it would not be subject to preemption. If this were a mandate, it would be an open

question if it were a component of the payroll tax. Mr. Carl asked if the preemption would apply if a state required patient assignment of benefits. Mr. Sushelsky responded that if the requirement applied to insurance companies and required insurance companies to allow assignment as part of the plan it would not be preempted. However, if the requirement applied to the plan, the requirement would fail.

V. Rebalancing Health Care in the Heartland.

Dr. James Merchant, Dean, University of Iowa College of Public Health and Senior Advisor to the President for Public Health Programs and Policy, and Chairperson of the Health Data Research Advisory Council, distributed an advance copy of the Summary of the Rebalancing Health Care in the Heartland Forum 2 that was held on June 19, 2007, in Des Moines. Dr. Merchant reported that Forum 3 will be held on December 3 and 4 and focus on national health care policy.

VI. Answers to Questions From Previous Commission Meetings.

Dr. Pete Damiano, Director, Public Policy Center and Professor, College of Dentistry, University of Iowa, presented "Questions Answered Sort Of" in response to questions presented at earlier Commission meetings relating to health care system frustrations, the cost of care in Iowa, the cost of a state-supported insurance expansion, and dental insurance.

Health Care System Frustrations. One frustration is that the health care system is a health care "sector," not a system, made up of microsystems such as the Veterans Administration. The health insurance system is largely employer-based, and insurance is an employer-provided benefit which is not designed to keep the population healthy and which leads to underinsured populations. The only insurance product designed to keep the population healthy is the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

Defining who is underinsured is a source of frustration. Even with insurance coverage, costs of health care lead to a negative impact on health and significant financial hardships for families. Also, many people perceive that they are underinsured because their coverage does not pay for everything they think it should cover. The meaning of "underinsured" was evaluated in the Iowa Household Health Survey for Children in 2005. In the survey, defining who was underinsured was accomplished by asking who had an unmet need or were stopped from getting care in the last year; who had a problem paying for uncovered services, based on how well their insurance met their needs; and who worried about paying for care and the impact of worry on the family.

Of those reporting an unmet need for medical care, the percentages for those with either Medicaid or private coverage were small. Those with private coverage had slightly more of a problem paying for uncovered services for a child. Medicaid met the needs of the respondents' children better (55 percent) than private insurance (29 percent), and met parents' needs better (46 percent) than private insurance (27 percent). Sixty-two percent of uninsured parents worried a great deal about paying for a child's care, while 11 percent or fewer of parents with Medicaid or private insurance worried a great deal about this. Worrying about paying for a child's care makes a great impact on quality of life for families.

Suggested adjustments to address health care system frustrations include the medical home concept and electronic health records. The medical home is an attempt to bring together the

disjointed aspects of a person's care and is not just a person or place, but is a way of providing coordinated, comprehensive, prevention-oriented care. The difficulty is in changing provider and patient behavior and in health care implementation. Electronic medical records are an attempt to bring together disjointed pieces of information, but the timeline for implementation is uncertain.

Costs of Health Care. Based on 2004 data, Iowa spends $15 billion annually on health care, ranking 22nd in the nation. California spends the most at $167 billion and Wyoming spends the least at $2 billion. Iowa state government spent $2.7 billion annually, based on 2003 data, ranking 18th in the nation. New York spent the most at $46 billion and Wyoming spent the least at $800 million.

In Iowa, in decreasing percentages the most is spent on hospital care (38 percent with the United States percentage being 36.5 percent), physician care (26 percent with the United States percentage being 29 percent), drugs (14 percent with the United States percentage being 14 percent), nursing home care (11 percent with the United States percentage being 7.4 percent), other (8 percent) and dental (5 percent).

The average spending per person nationally is $1,243 for those younger than 5 years of age, $1,108 for those 5-17 years of age, $1,282 for those 18-25 years of age, $2,277 for those 25-44 years of age, $4,647 for those 45-64 years of age, and $8,647 for those 65 years of age and older. By sex, the average spending per person nationally is $2,836 for males and $3,715 for females.

The highest percentage of health care costs is attributable to those 19-44 years of age (26 percent) with those age 75 and older ranking second (22 percent). Total spending for mental health in Iowa in 2003 was $217-$225 million with the highest percentage (67 percent) attributable to other services, 19 percent being attributable to other 24-hour services, and 14 percent being attributable to inpatient services.

Cost of State-Subsidized Health Insurance Expansion Options. State-subsidized health insurance expansion options include covering more children in Medicaid or hawk-i, covering more parents in Medicaid, and subsidizing employer-based options. Department of Human Services (DHS) estimates for covering children up to 100 percent of the federal poverty level (FPL) under Medicaid, which would cover an additional 16,000 children, would cost a total of $32 million ($19 million federal and $13 million state); covering children between 100 and 133 percent of the FPL under Medicaid, which would cover an additional 5,000 children, would cost a total of $11 million ($8 million federal and $3 million state); and covering children between 134 and 200 percent of the FPL under the hawk-i Program, which would cover an additional 11,000 children, would cost a total of $25 million ($18 million federal and $7 million state). The DHS estimates for covering parents up to 100 percent of the FPL under Medicaid, which would cover an additional 31,000 parents, would cost a total of $128 million ($79 million federal and $49 million state); and covering parents between 100 and 133 percent of the FPL under Medicaid, which would cover an additional 20,000 parents, would cost a total of $81 million ($50 million federal and $31 million state).

Employer-based options include tax credits based on the size of the firm. For firms under 25 employees, there are 150,000 eligible individuals and 120,000 are currently uninsured. Under the projection, 32,000 employees would be newly covered at a cost of $17 million. If the state provided for reinsurance and subsidized the highest-cost employees, reinsurance would cost $3 million for 11,000 individuals. This figure does not include actual claims.

Dental Insurance. Twenty percent of Iowa's children are dentally uninsured, down from 25 percent in the year 2000. Lower income children are more likely to have dental insurance, with 16 percent of low-income children being dentally uninsured. The dentally uninsured are more likely to have an unmet dental need, are less likely to have an annual visit, and are less likely to have a regular source of care.

In 2005, the Iowa General Assembly enacted legislation, 2005 Iowa Acts, H.F. 841, requiring that by July 1, 2008, every Medicaid recipient who is a child 12 years of age or less must have a designated dental home. The legislation did not contain funding or any specifics about how to accomplish this requirement. In response to the legislation, DHS partnered with the Department of Public Health, the Iowa Dental Association, the Iowa Dental Hygienists' Association, Delta Dental of Iowa, and the University of Iowa College of Dentistry to develop a proposal that would fulfill the dental home mandate. The result is called the I-Smile Dental Home Project.

The four objectives established for the I-Smile Program are to improve the dental support system for families, to improve the dental Medicaid program, to implement recruitment and retention strategies for underserved areas, and to integrate dental services into rural and critical access hospitals.

The rationale for the I-Smile Program is that only 45 percent of children enrolled in Medicaid have an annual dental visit, low-income children are most at risk for severe and untreated decay, early preventive dental services demonstrate significant cost savings, and tooth decay can be prevented and prevention must occur at an early age. However, dentists are reluctant to accept Medicaid-covered patients because of low reimbursement and perceived noncompliance with dental appointments. There are too few dentists in many parts of the state with 79 counties estimated to be designated dental shortage areas. Additionally, many dental practices are busy and do not accept any new patients, and many general dentists do not see children under age three.

In order to improve access to a dental home, the I-Smile Program would contract with a familiar dental insurance carrier to improve dentist participation in Medicaid, create a dental screening payment code and specific reimbursement amounts for physicians, allow reimbursement for oral screenings and fluoride application by nondental providers, and reinstate coverage of periodontal services to adult Medicaid enrollees.

To improve support to families, the I-Smile Program would provide funding to local Title V child health agencies to increase the dental program infrastructure, increase funding to strengthen the state Title V child health database system to track patients, fund public oral health education and promotion, and fund training programs and create mandatory continuing education requirements for dental and other health care providers regarding children's oral health.

The program would address recruitment and retention of providers by creating a dentist/dental hygienist student loan repayment program to increase the dental workforce in the shortage areas and would work with rural hospitals to develop dental clinics.

The 2007 General Assembly appropriated $1.2 million to support Title V clinics which allowed for the leveraging of an additional $200,000 in federal funds. With the funding, a dental hygienist associated with each of the 23 child health agencies was hired to provide health education and preventive services, and to coordinate with local dentists and physicians. However, the recommendation to contract with a familiar dental insurance carrier was discussed, but not funded.

VII. Fifty State Survey of Children's Health Care Coverage.

Ms. Jody Ruskamp-Hatz, Senior Policy Specialist, National Conference of State Legislatures, presented "The State of Children's Health: A National Perspective." The four state strategies used have been Medicaid/State Children's Health Insurance Program (SCHIP) eligibility increases, public program buy-in which allows children at higher incomes to purchase coverage, premium assistance for employer-sponsored insurance, and enhancing outreach, administrative simplification, and coordination.

Medicaid Compared With SCHIP. There are differences between the Medicaid and SCHIP programs to consider. Medicaid coverage is required for children newborn to age six. The SCHIP is generally provided for children above the Medicaid levels, typically up to 200 or 300 percent of the FPL. Medicaid is an entitlement to beneficiaries and the states, while SCHIP is an entitlement only to the states. Enrollment caps are prohibited under Medicaid, while permitted under SCHIP. Financing of Medicaid is a guaranteed federal match, while financing for SCHIP is capped at an enhanced federal match rate. Under Medicaid, the scope of coverage provides options to impose benchmarks and provides for EPSDT wrap-around coverage. Under SCHIP, however, there are no mandates for EPSDT coverage. Cost-sharing and premiums are generally not allowed under Medicaid for children who are mandated to be eligible, but may be assessed for those over 150 percent of the FPL. Under SCHIP, cost sharing is permitted up to 5 percent of the family income. Coverage under both Medicaid and SCHIP continues to grow and cover more children annually.

State Actions in 2006-2007. State actions to cover children in 2006-2007 include plans to define near-universal access to affordable health care in seven states, expansions for children's eligibility in 13 states and the District of Columbia, and plans to improve outreach and enrollment in six states including Iowa. Illinois implemented the All Kids program in 2006 that builds on the state's Medicaid and SCHIP programs. The program is entirely funded by state funds, covers children regardless of immigration status, and requires that a child be uninsured for 12 months prior to enrollment. As of April 2007, approximately 50,000 children had enrolled in the program. Pennsylvania created a Cover All Kids Program that expands SCHIP from 200 percent to 300 percent of the FPL to cover children. Additionally, families with incomes above 300 percent of the FPL may buy in to SCHIP at full cost. Tennessee enacted CoverKids which covers children up to 250 percent of the FPL and it is expected that 20,000 children will enroll in the program in the first year. Nine million children were uninsured nationally in 2005, and of these it is estimated that 74 percent are eligible for Medicaid or SCHIP.

Ways to Increase Enrollment. Enrollment can be increased with improved outreach including permitting mail-in applications, eliminating face-to-face interviews, eliminating the asset test, allowing self-declaration of income, allowing presumptive eligibility for children and pregnant women, and allowing continuous 12-month eligibility.

Practices That Result in Decreased Enrollment. Wisconsin experienced a 22 percent decline in enrollment when it established a new employer verification process, and Washington reversed a policy of applying more strict eligibility criteria when it was demonstrated that such rules led to 39,000 children being dropped from the programs.

State Initiatives to Improve Enrollment. Connecticut enacted a law to automatically enroll all uninsured newborns in their SCHIP Program and presumptive eligibility for children applying for

Medicaid. The law also provides a single point of entry to apply for both programs. In Texas, a community outreach campaign for SCHIP extended continuous eligibility for children to 12 months and eliminated a 90-day waiting period. Arizona lifted a gag rule in SCHIP to allow schools to participate in outreach and enrollment efforts.

Premiums and Copays. Thirty-five states charge premiums or enrollment fees for children's coverage. Federal law prohibits cost sharing or premiums for Medicaid children, although some states require them through waivers, and the only copay for the separate Iowa SCHIP Program, hawk-i, is a $25 fee for improper use of the emergency room.

State Reforms. As of June 2007, 31 states have enacted or announced coverage initiatives for children and these reforms rely heavily on federal financing from SCHIP and Medicaid. New guidelines from the federal administration may limit state efforts to expand coverage. One example is New York which requested an expansion to 400 percent of the FPL but was denied on September 10, 2007.

Outlook for SCHIP. The deadline for reauthorization of SCHIP is September 30, 2007. The administration has threatened to veto both the House and Senate versions of the reauthorization bill but there is work on a compromise. Ms. Ruskamp-Hatz provided a chart comparing the House and Senate versions of the SCHIP reauthorization proposals.

VIII. Health Care Costs — Spending and Funding.

Mr. Richard Cauchi, Director, Health Program, National Conference of State Legislatures, Denver, Colorado, discussed increasing health costs; insurance: costs versus coverage; finances; and the states' mix and match solutions.

Cost Drivers. Mr. Cauchi noted that long-term health care cost drivers include medical technology, prices, unhealthy behavior, the aging of the population, inefficiency, inappropriate use (overuse and underuse), end-of-life interventions, and liability. There is no clear agreement among economists, however, about cost drivers.

Cost Growth Levels. From 1990 to 2007, cost growth levels have fluctuated, with cost growth in 1990 being 17.1 percent having leveled off at 6.1 percent over the last few years.

Type of Plan. The majority of employer-sponsored health insurance is provided through preferred provider organizations (PPOs).

Average Annual Premium. In 2007, the average premiums across all types of plans were $4,479 ($694 paid by the worker and $3,785 paid by the employer) for a single person and $12,106 ($3,281 paid by the worker and $8,824 paid by the employer) for a family.

What Is Affordable. Economists differ in defining what is affordable in the context of insurance including that individuals with low incomes can pay only small amounts toward health care; the "upper bound" of affordability is defined as 8.5 percent; a sliding scale of affordability progressing from 4 percent to 8.5 percent is needed for people with incomes between 300 percent and 600 percent FPL; what is affordable might not be available; and the Lewin model which used 7.5 percent of income in defining affordability.

Administrative Costs. Insurance is more costly to administer for small groups. The cost of administration for a group of one to four employees is 37.2 percent compared with 22.5 percent for groups of 20-49 employees, 13.7 percent for groups of 100-499 employees, and 5.5 percent for groups of 10,000 or more employees.

Care Management Programs. The larger the employer, the more likely care management programs such as a health website, health risk assessments, nurse advice lines, and other programs will be offered.

Strategies for Moderating Health Care Costs. Strategies to moderate health care costs include:

- Moving people into a coverage status. Cover everyone and thereby reduce the level of uncompensated care. This strategy provides a larger risk pool that is more stable, but even though people are more healthy, it might not reduce costs. Everyone must be in the pool in order to moderate costs.
- Using consumer-driven plans such as health savings accounts (HSAs), which have had some success. The HSAs allow for tax-free accumulation of savings, but the plan must be a high-deductible plan. The HSAs are growing in use as a tool. Even though they may offer a lower premium, they have high deductibles and the issue is, who will pay the high deductible — employer or individual.
- Examining insurance mandates: Some states have tried in the past to reduce or eliminate mandates, but repeals do not necessarily result in cheaper premiums. There have been few recent additions of new mandates, with some exceptions.
- Certificate of need (CON) review. This is not an easy solution and is not black and white. CON laws are used in 36 states. In Iowa in 2006, 19 applications were made of which 14 were approved.
- Expanded use of cafeteria (IRS section 125) plans. These plans allow a full tax deduction for health premiums. The employer does have to pay to set up these plans, but there is a cost savings to the employee. Massachusetts' universal plan requires that IRS section 125 plans be offered. (Massachusetts estimates a 26 percent savings to the employee and a 1.86 percent savings to the employer.) In Rhode Island, employers with over 50 employees must offer the cafeteria plans, but employers are not required to pay for them. Other states such as Washington and Missouri have similar provisions for IRS section 125 plans.
- New purchasing coalitions. Voluntary purchasing pools were used in the 1990s, but costs did not seem to drop. New coalitions have developed such as those starting with public sector employees and then combining with private employees to leverage greater market share. Examples are the Minnesota Smart Buy Alliance and the Puget Sound Health Alliance in Washington.
- Value-driven health purchasing. Provisions have been built into public/private partnership purchasing contracts to allow for evidence-based medicine, new information technology and e-records, tiered premiums, pay-for-performance

incentives and measures, and designation of high-performance providers as "centers of excellence."

- Focus on wellness and prevention. Traditional insurance focuses on treatment and some low-cost screenings. There is a growing trend toward voluntary, educational campaigns for wellness, exercise, and healthy diet. Some include incentives for weight loss, not smoking, body mass index improvement, and early treatment of preventable disease.
- Cost transparency and disclosure. Cost, price, and quality information is a critical component of value-based purchasing and consumer-driven approaches. The process involves collecting data from providers and health plans and applying quality, efficiency, and value measures. At least 12 states have enacted price disclosure laws and California, Florida, and Maryland have state-run consumer websites on hospital charges and readmission rates.
- Uniform quality measures and reporting requirements. Multiple purchasers join to establish uniform quality measures which translate into standard data requirements for health plans or providers. State employee benefit plans in Massachusetts, Washington, and Wisconsin have these policies.
- Reverse poor quality and waste and use the savings from current waste and inefficiency. An example is Pennsylvania.

Small Businesses. States working on making insurance more affordable for small businesses include Montana (currently a waiting list for small businesses to be subsidized due to funding constraints — funded by a new tobacco tax), New York, West Virginia, Tennessee, New Mexico, Oklahoma, Arkansas, and Arizona. The Indiana "check-up plan" provides a 50 percent small business wellness program tax credit, requires insurance companies to allow parents to keep children on family insurance plans up to age 24, allows companies to use pretax dollars to pay for employee health insurance coverage, expands the state's children's health insurance program to an additional 39,000 children, and increases the eligibility for pregnant women on Medicaid — funded by a cigarette tax increase. Cover Tennessee is a public/private partnership plan for small employers and uninsured workers with incomes below 250 percent of FPL. Cover Tennessee is guaranteed access to basic, major medical coverage for $150/month with costs shared equally by the individual, the employer, and the state.

Building Consensus. In reforming the health care system, building consensus is key. One example is Colorado's Blue Ribbon Commission made up of 27 members. The commission issued an RFP to seek reform plans. Thirty-one were received and the commission narrowed them to four. Political successes are most common after all stakeholders are at the table and there is bipartisan endorsement.

Accurate Data. Good, current health data is critical, but hard to find and compare. The Lewin Group has an effective model, the Health Benefits Simulation Model.

IX. Health Care Policy Strategies.

Ms. Laura Tobler, National Conference of State Legislatures, discussed health reform in the states. There has been a persistent increase in the number of uninsured over time. Recent state health reform actions include:

- Attempts to reduce the number of uninsured including using exchanges/connectors and IRS section 125 plans to provide a single place for persons to purchase insurance coverage; requiring all residents to buy health insurance; involving employers in the financing of coverage through taxes or assessments; premium assistance through strategies that leverage state contributions with employer and employee dollars or that create purchasing pools; subsidizing insurance for the poor; allowing young adults to remain on their parent's or guardian's insurance longer; expanding or leveraging Medicaid or SCHIP; providing for reinsurance; using limited benefit plans; creating high-risk pools and other pooling; using premium caps; increasing tax credits on residents/employers; and increasing provider fees/taxes to pay for subsidized insurance.
- Focusing on quality initiatives. Most reforms include a quality component to help people make informed health care decisions, lower costs, reduce medical errors, and reduce disparities in health care.
- Focusing on appropriate care for chronic disease. Five percent of the population has the greatest impact on health care costs, and the sickest 10 percent of the population account for 64 percent of expenses. At least seven of the 2007 state proposals include aggressive programs to improve management of chronic disease including Vermont's Blueprint on Health.
- Focusing on prevention and wellness initiatives. Almost all 2007 health reform proposals include prevention strategies and policies. There is more emphasis on reducing obesity and increasing exercise, addressing smoking, and encouraging good nutrition. There is a focus on wellness and personal responsibility in private and public insurance such as allowing premium discounts/rebates, employer tax credits, focusing on state employees, and creating statewide wellness programs. Workplace-based health promotion programs may save an average of $3.50 for every dollar spent. Rhode Island created WellCare to provide an affordable health insurance product focused on primary care, prevention and wellness, actively managing chronic illnesses, and using evidence-based care in the most appropriate setting.
- Focusing, concurrently, on cost containment.
- Access to health care. Many states use community health centers to provide care to the uninsured and Medicaid recipients. Others have looked into incentives for doctors to practice in underserved areas such as the National Health Service Corps Scholarship Program and the National Health Service Corps Loan Repayment Program. Forty-five states have loan repayment programs for doctors who practice in underserved or rural areas. At least nine states have considered changing scope of practice laws.

X. Workgroup Discussions.

The Commission members broke into two workgroups: providing funding, containing costs, and improving quality; and increasing coverage and access to care. The small groups were instructed to begin by asking questions of the NCSL experts to explore what programs or initiatives from other states might be included in the Commission's legislative package and to then discuss possible pieces of the Commission's legislative package to move from concepts to more concrete ideas. The small groups were told to report back to the entire Commission their questions and key discussion points.

The following is a summation of the results of the workgroups:

A. Providing Funding/Containing Costs and Improving Quality Workgroup.

Ideas to move forward:

1. Adequate staffing (enough providers).
2. Transparency.
3. Electronic health records.
4. Chronic disease management/wellness and prevention — should involve all stakeholders — consumers, providers, and payors should share the responsibility in improving health. Encourage private groups to provide incentives. Use data driven/evidence-based approach. Use public/private partnership. Use Centers for Medicare and Medicaid Services' model to screen for chronic diseases (Elder Affairs/Public Health).
5. Look at best practices — data driven — efficiencies. Look at Commonwealth Fund Report and do better on the existing indicators in Iowa.
6. Focus on segments like small business and rural (e.g., tax credits, public/private partnerships) — Lewin Group.
7. Explore using the Medicare model in Iowa to create a small business package to put everyone on a level playing field.
8. Modified connector — use pretax IRS section 125 plans. State may act as administrator.
9. Improve quality — use evidence-based outcomes or results-based medical care. Attack as a public health problem.
10. Have a common preferred drug list for the state — Smart Buying Program in Minnesota.

Issues that require more research:

1. Cost/benefit analysis for wellness?
2. Minnesota plan and results?
3. What states have chronic disease/wellness/prevention plans?
4. What states are doing a good job with HSAs?
5. How do you address the portability of insurance?
6. What are states doing with voluntary programs (Indiana)?
7. Can we look at Medicare as an example?
8. Information on the Asheville Project in North Carolina?
9. Are there states with both mandates and voluntary?
10. Insurance consumer advocate?
11. Can we use Commonwealth Fund Report: Best In Class?

B. Coverage — Expanding Coverage/Enhancing Access to Care/Promoting Prevention and Wellness Workgroup.

Ideas to move forward:

1. Individual mandate (cover 19 to 24-year-olds, affordable, subsidy).
2. Patients' rights.
3. Medical home.
4. E-medical records.
5. Connector (hawk-i as an example).
6. Wellness.
7. Insurance availability — merger — individual and small market.
8. Doable.
9. Hatch factor — do what's right.
10. Funding options.
11. Look at cost shifting.

The co-chairpersons stated that they would review the ideas and issues presented by the workgroups, consolidate the issues for subcommittee work, and then assign subcommittees to work through the details prior to the next meeting in October.

XI. 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. Health Hostel Information.
2. "2007 Iowa Employer Benefits Study" by David P. Lind & Associates LLC.
3. "Data Council Presentation" by Dr. Damiano.
4. "ERISA Preemption and State Health Reform" by Jay E. Shushelsky, AARP Foundation Litigation.
5. "Health Reform in the States" by Laura Tobler, National Conference of State Legislatures.
6. "Long-Term Care Insurance Report" - long version - submitted by Commissioner Voss.
7. "Small Group Discussion Instructions".
8. "The State of Children's Health - A National Perspective" by Jody Ruskamp-Hatz, National Conference of State Legislatures.
9. Cafeteria Plans Information submitted by Dick Cauchi, NCSL.
10. Commission Progress Report submitted by Co-chairperson Foege.
11. Employer Health Benefits - 2007 Summary from Dick Cauchi, National Conference of State Legislatures.
12. Groups for September 19, 2007.
13. Health Care Costs & Spending: Latest Strategies by Dick Cauchi, National Conference of State Legislatures.
14. Health Insurance Survey of Farm and Ranch Operators submitted by Dick Cauchi, NCSL.
15. Joint Principles of the Patient-Centered Medical Home submitted by Dr. David Carlyle.
16. Near-Universal Health Reform Financing submitted by Dick Cauchi, NCSL.
17. SCHIP Information presented by Jody Ruskamp-Hartz, NCSL.
18. States & Small Business Health Insurance: An Overview by Dick Cauchi, National Conference of State Legislatures.

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