Legislative Services Agency

MINUTES

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

October 17, 2007 — Sixth Meeting

MEMBERS PRESENT:

Senator Jack Hatch, Co-chairperson
Senator Joe Bolkcom
Senator Jim Seymour (alternate)
Senator Amanda Ragan
Mr. John Aschenbrenner
Dr. David Carlyle
Ms. Amy DeBruin
Dr. Steven Fuller
Ms. Barb Kniff
Dr. Timothy Kresowik
Ms. Julie Kuhle
Ms. Janice Laue
Mr. Eric Parrish
Ms. Patsy Shors
Mr. Russ Sporer

Representative Ro Foege, Co-chairperson
Representative Elesha Gayman (alternate)
Representative Clarence Hoffman
Representative Mark Smith
Representative Linda Upmeyer
Ms. Sarah Swisher
Mr. Joe Teeling
Ms. Sharon Treinen

Ex Officio Members:
Mr. Kevin Concannon
Mr. John McCalley
Mr. Tom Newton
Ms. Susan Voss

MEETING IN BRIEF

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

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

I. Procedural Business

Call to Order and Adjournment. Co-chairperson Hatch called the sixth meeting of the Legislative Commission on Affordable Health Care for Small Businesses and Families to order at 9:04 a.m. on October 17, 2007, in the Sioux City Convention Center, Sioux City, Iowa. The meeting was adjourned at 3:56 p.m.

II. Approval of Minutes, Welcome, Review of Agenda

The minutes of the September 19, 2007, meeting were approved as distributed. Co-chairperson Hatch noted that being the sixth meeting of the Commission, this was "decision time." The Commission members had been assigned to one of seven subcommittees and many had already met. The October and November meetings are to be used to frame recommendations. Any decisions during the day are to be based on the consensus of the workgroups and then are to be reviewed by the whole Commission in the afternoon. The workgroups may also be asked to look at additional areas of interest that have developed or will develop in the next two months from legislators, interest groups, or others.

Co-chairperson Foege welcomed the Commission members and others to the meeting. He recognized local Representative Roger Wendt who welcomed everyone to Sioux City. Local Representative Wes Whitead was also present for the meeting.

III. Commission Expense Disbursements

A report of the disbursements from the Commission's appropriation was distributed. The report will be updated monthly and is available on the Commission's Website.

IV. Iowa Rural Health Association Survey Report

Overview. Dr. William Appelgate, Vice President for Planning and Technology, Des Moines University, presented the results of a survey sponsored by the Iowa Rural Health Association in partnership with Iowa Farm Bureau, Iowa Health Systems, Partnership for Better Health, and Des Moines University, coordinated by Dr. Appelgate and designed and administered by Selzer and Company.

Purpose and Methodology. The purpose of the survey was to examine the views and opinions of Iowans regarding accessibility, utilization patterns, health value issues, and personal health status in order to provide information for policymakers and practitioners to better serve Iowans and address rural health issues. One thousand Iowa adults comprised of a statewide sample of 700 and an oversample of 300 defined as rural residents participated in the survey. There were 447 rural and 553 nonrural respondents. "Rural" was defined as living on a farm and working as a farmer or living in a small town or in the country at least 50 miles from a major city in Iowa or its suburbs. The margin of error for the survey was +/- 3.1 percentage points for the entire sample, and the method of the survey was a telephone interview lasting approximately 16 minutes during the period July 18 through 23, 2007. The survey measures self-perceptions regarding health and health care.

Attitudes Toward Health. The general results of the survey demonstrate that the vast majority of Iowans, 85 percent, say their health is excellent or good (36 percent excellent, 49 percent good, 10 percent just fair, and 5 percent poor); more Iowans say their health is improving than declining; but, 36 percent (the same as reported to the Centers for Disease Control and Prevention) report a serious health problem or condition that requires frequent medical care (11 percent arthritis, 10 percent high blood pressure, 8 percent heart disease, 6 percent diabetes, and 6 percent depression). Iowans are not complainers, and this may serve as a reminder of the mind-set of Iowans when communicating with Iowans about their health.

Health Insurance Coverage. Nine in 10 Iowans report they have health insurance coverage. Younger Iowans (under age 35) make up one in three of the uninsured. Iowans report that the time spent uninsured is mostly short (31 percent less than one year, 27 percent one to two years, 26 percent longer than two years, and 16 percent never covered); the uninsured in the survey were more likely to report chronic disease (38 percent) than the insured (36 percent); and most insured Iowans (those with some type of insurance including Medicare) are satisfied with their current health care coverage (43 percent very good, 36 percent reasonably good, 12 percent adequate, 7 percent not really adequate, and 2 percent not sure). However, in spite of the perception of Iowans that they have reasonably good coverage, rural residents had less generous insurance coverage.

Access to Health Care. Ninety-four percent of respondents reported that they have a regular place that they go for treatment (have established "medical homes") and 93 percent reported that their "medical home" was within a reasonable distance. The survey demonstrated that transportation was more of an issue with the nonrural than the rural residents, which is counterintuitive, but was also based upon the individual's perception of what was a "reasonable" distance to travel. When insurance coverage was available for a selected provider, the visits to the provider increased. Rural Iowans are less likely to have insurance that pays most of the costs in some categories, and therefore may have diseases that go undiagnosed and untreated.

Attitudes Toward Prevention and Compliance. A majority of Iowans in the survey are motivated to learn more about preventions. Based on the survey, Iowans accept individual responsibility for acting in ways to keep health care costs lower (52 percent agreed that it was "up to me" to help keep everyone's costs down by taking care of themselves and 56 percent agreed that individuals can reduce their health care costs and suffer less if they change their health behaviors). Forty-six percent of the respondents stated that they absolutely trust their primary care provider, but often base compliance decisions on the perceived value for the cost.

Conclusions. Iowans are generally upbeat about the health care climate of the state and their personal health. The study indicates that there is a perception of reasonable access to health care professionals, though pockets of problems may exist. Rural Iowans are more likely to be covered by insurance, and are more likely to report reasonable access to health care professionals, although the policies of rural residents cover less than those of nonrural residents and noncompliance might be an indicator that the cost of health care poses an obstacle to accessing health care. Rural and nonrural Iowa residents are generally more similar than different in their attitudes toward health care, and it is not a matter of living in a rural area but of what insurance covers.

The study does not mistake perceptions for concrete indicators. Because rural Iowans do not seem to believe that they are underserved, it might not be helpful to start by decrying the health care crisis in rural Iowa. Iowans have a good outlook on health, have an interest in prevention, and accept individual responsibility for their health. When respondents were asked to identify the source of their insurance, there was some confusion regarding whether a person with Medicare reported having private insurance instead. The majority of the rural respondents did have private insurance.

Discussion. Senator Seymour commented that 10 to 15 years ago there was not as much satisfaction in the rural areas with health care access, but that increased recruitment and the use of midlevel health practitioners has improved access. Mr. Sporer noted that in sales staff meetings insurance agents commented that the workforce shortage forces employers to offer insurance as a benefit and that increases in premiums were less this year. Rural areas do see more individual plans and this presents a problem when these individuals retire or move to other employment. Ms. Swisher noted that another recent study demonstrated that rural individuals pay a larger percentage of their income for health insurance coverage and this is similar to the challenge that small businesses have.

V. Pharmaceutical Policy Report

Overview. Dr. Jane DeWitt, College of Pharmacy and Health Sciences, Drake University, and member of the Health Care Data Research Advisory Council, presented a report developed by Dr. DeWitt in collaboration with Dr. Bernard Sorofman, College of Pharmacy, University of Iowa, and also a member of the advisory council.

Dr. DeWitt noted that the presentation is a preliminary report and that a written report would be submitted at a later date, taking into consideration any directives given by the Commission following the presentation.

Goals. Dr. DeWitt noted that the goals of the presentation were to summarize the policy tools that improve access to medications and medication-associated services and that enhance health outcomes and reduce program costs.

Medication Results. Medications save lives, improve the quality of life, decrease hospitalizations, reduce work sick days, and are cost-effective if the patient has access to both the medications and the knowledge on how to manage them. However, medications can take time to create positive outcomes and medication costs may increase relative to other measures of outcomes such as avoidance of a critical incident or surgery.

Pharmacists and Use of Pharmaceuticals. Pharmacists were the most visited health care provider in the last year and insurance in both rural and nonrural areas pays for most prescription medications. Even given these data, however, Iowans reported that they did not refill a prescription, cut back on a dose, or stopped a prescription medication, due to cost.

Medication Knowledge. Medication monitoring and management are important, as adverse drug events as well as failure to consume medications can result in increased morbidity and mortality and increased costs. Ten percent of hospitalizations and 23 percent of nursing home admissions are related to nonadherence to medication regimens. This results in a cost of $100 billion and

125,000 deaths, annually. Additionally, adverse drug events are responsible for 3.1 to 6.2 percent of increased hospitalization and $887 million annually.

Role of Pharmacists. A pharmacist's intervention can address preventable adverse drug events and nonadherence. Pharmacists are necessary to assure appropriate and timely access to medications and optimal utilization of medications.

Existing Measures to Improve Access to Medication and Involve Pharmacists. Cost-saving measures currently in existence in Iowa include the use of a preferred drug list, prior authorization, and generic substitution. In 2004 Express Scripts reported that the overall adjusted generic fill rate in Iowa was 50.8 percent. If generic use over six therapeutic classes would be maximized, this would save an additional $204 million. The Iowa Prescription Drug Donation Repository Program was enacted in 2005 to provide prescription drugs to low-income Iowans by authorizing medical facilities and pharmacies to redispense prescription drugs and supplies. Collaborative practice agreements provide for collaborative drug therapy management between physicians and pharmacists. The pharmacists work within a defined protocol to perform patient assessments; order drug therapy-related tests; and select, initiate, monitor, and adjust drug regimens.

Initiatives. Initiatives to consider include optimization of the federal 340B Drug Pricing Program, state prescription assistance programs (42 states, not including Iowa, have one or more such programs), patient assistance programs to facilitate access to free medications through the pharmaceutical industry (Iowa is developing this program with the Iowa Prescription Drug Corporation), wellness and health promotion (including immunizations, medication for prevention, and screenings), disease state management (such as the Asheville, North Carolina program), medication therapy management (established in Iowa in 2000 with the high-risk Medicaid population and a component of Medicare Part D), and the pharmacy home.

Pharmaceutical Policy Goals. Iowans must have access to affordable medications and must have access to medication information, counseling, and monitoring.

Discussion. During the discussion that followed the presentation, Dr. DeWitt suggested that electronic prescribing can save time and would allow for monitoring. Electronic or "E-prescribing" also provides for alerts for drug interactions. A big problem is inappropriate use of prescription drugs for children with behavioral health issues, which can lead to adverse drug events. Zero copays remove any barrier to adherence to drug therapy. Community pharmacies provide a mechanism for the development of the pharmacy home.

VI. Electronic Health Records

Representative Upmeyer presented information regarding the Electronic Health Records Task Force created in 2006 legislation which directed the Department of Human Services to establish a task force to provide a structure to enable the state to act in a leadership role in the development of state and federal standards for and in the implementation and use of an electronic health records system. Representative Upmeyer is a member of the task force and suggested that a more formal task force should be established in order to be able to accept grants for initiatives to move the development of electronic health records forward in the state.

The existing task force has come a long way since the first meeting when interoperability seemed insurmountable. There are many complex issues to address including privacy, identity theft, legal aspects, technical know-how, and destruction of information. Representative Upmeyer noted that data suggests that the use of electronic health records could save 8 percent of a $2 trillion national health care budget in exchange for a 1 percent investment. At the last meeting of the task force, the Commission members were invited to a presentation by Dr. William Yasnoff regarding health record banking and the materials are available at the Commission's Webpage.

VII. Workforce Shortage Preliminary Report

Ms. Julie McMahon, Division Director, Health Promotion and Chronic Disease Prevention, Department of Public Health (DPH), distributed a preliminary report on Iowa's Health and Long-term Care Workforce. Ms. McMahon asked the commissioners to review the framework for the final report presented in the preliminary report and suggest any changes prior to its completion. Since the Commission approved the study in August, DPH has been working with other state agencies and stakeholders to pull together existing information regarding the workforce shortage.

The final report will include background research and supply and demand information for various health professions as deemed necessary by the stakeholders and the Commission. Although the preliminary report does not include recommendations, 150 stakeholders have been invited to participate in the health care workforce shortage summit to be held on November 9, 2007, and the final report will include the recommendations gleaned from the work at the summit. The final report will include action steps for the near-term (one to two years) and the long-term (two to five years). The report will provide information about supply and demand projections for various professions, the challenges, the impact on Iowans, and the recommendations by professional groups. Even though the legislation requires a report to be submitted by January 15, 2008, DPH hopes to have the final report available for the Commission's last meeting on December 19, 2007.

VIII. Public Hearings — Governors' Recommendations

Co-chairperson Hatch referenced the minutes from the public hearings co-hosted by former Governors Terry Branstad and Thomas Vilsack and the summary of the special meeting during which the former Governors provided their recommendations to the Commission. Co-chairperson Hatch noted that it was significant that the former Governors agreed to such a great extent about providing health care coverage to all Iowans.

IX. Workgroup Meetings

Following instructions provided by the Commission facilitator, Mr. Bruce Feustel, the members of the Commission broke into workgroups to address specific health care concepts:

- Workgroup 1: Workforce Shortages.
- Workgroup 2: Electronic Medical Records.
- Workgroup 3: Medical Home.
- Workgroup 4: Health Care Coverage (formerly Individual Mandate).
- Workgroup 5: Purchasing Pools for Medications — State Preferred Drug List.

- Workgroup 6: Patient Rights.
- Workgroup 7: Funding.

Following their meetings, the workgroups presented their reports to the Commission as a whole. The results of the workgroup deliberations are summarized in the reports attached as attachment I.

The co-chairpersons encouraged the workgroups to continue their work in the interim period prior to the meeting in November.

The co-chairpersons suggested that the date for the December meeting be changed from December 19 to December 5 or 12, 2007. The members will be contacted to determine if the date should be changed. (After a poll of member availability was completed following this meeting, the co-chairpersons determined the meeting would remain on December 19.)

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

Group 1 — Workforce Shortage Documents

1. The Future of Iowas Health and Long-Term Care Workforce — Preliminary Report
2. The Iowa Physician Workforce Report submitted by Stacey Cyphert

Group 2 — Electronic Medical Records Documents

3. Microsoft Health Records Site
4. Health Record Banking, Powerpoint — Yasnoff
5. Health Record Banking, Article — Yasnoff
6. Iowa Health Systems Current Use of HR
7. Health Information Technology Adoption in Physician Office — A Summary
8. Electronic Health Records Email

Group 3 — Medical Home Documents

9. Partnership for Prevention — Cost-effective Preventive Services
10. Wellness Article by Amy Winterfeld — NCSL
11. Wellness Overview — NCSL
12. State Workplace Wellness Initiatives
13. School Wellness Policies
14. Prevention and Wellness — State Health Reform
15. Healthy Indiana Plan
16. State Health Incentive Programs
17. States Promote Wellness
18. Vermont Blueprint for Health
19. I-Smile Dental Home Proposal
20. Commonwealth Fund — Medical Homes Promote Equity
21. Medical Home Definition — Iowa Collaborative Safety Net Provider Network
22. Advanced Medical Home — American College of Physicians

23. Suggested Resources — Med Home Concept
24. Improve Diabetes Care

Group 4 — Individual Mandate — Insurance Category Documents

25. Insurance Mandates 2007
26. Cover Tennessee
27. Expansion: Children and Adults Medicaid/hawk-i
28. Preventive Services — Priorities
29. Young Adults
30. Insurance Coverage for Young Adults
31. Insurance Cafeteria Plans
32. States and Small Business Health Insurance — Overview
33. What Affordable Health Care Means
34. Assessment of Health Care Reform Proposals
35. Wisconsin Health Plan
36. Iowa Long-Term Care Insurance Study — Summary
37. Universal Individual Coverage — National Risk Pool
38. Children's Oral Health
39. Minnesota's Smart Buy Alliance
40. Young Uninsured Adults — Commonwealth Fund
41. NCSL Memo — See Subsidies Heading
42. Medicare Expansion
43. Colorado Blue Ribbon Commission for Healthcare Reform — Proposals
44. Massachusetts Health Reform of 2006

Group 5 — Purchasing Pools for Meds — State Preferred Drug List Documents

45. Asheville Project — Chronic Diseases
46. Asheville Project — Diabetes
47. Minnesota — Diabetes Management
48. Pharmacists — Diabetes Management
49. Asheville Project — American Pharmacists Association
50. Pitney Bowes — Investment in Health
51. Benefit Design — Incentives
52. Pharmacy Purchases — 340B Programs
53. Pharmaceutical Bulk Purchasing Programs in the States

Group 6 — Patient Rights Documents

54. House File 514 — Insurance Consumer Advocate
55. Commonwealth Fund Report on Transparency
56. The Mystery of Hospital Pricing
57. Shopping for Health Care — Transparency
58. Cutting Infections
59. Leapfrog Group — Fact Sheets
60. NCSL — State Actions on Transparency

Group 7 — Funding Documents

61. Commonwealth Fund — Iowa Scorecard on Health System Performance
62. Vermont Catamount Health Plan

63. Health Care Cost Growth and Cost Containment Initiatives
64. Marshfield Clinic — Pay-for-Performance
65. Pay-for-Performance Initiative
66. Commonwealth Fund — Payment for Adult Primary Care
67. Payment Systems to Accelerate Value-Driven Health Care
68. Evidence — Informed Case Rates
69. Group Purchasing Arrangements
70. Minnesota's Smart Buy Alliance — Value-Driven Purchasing
71. Value-Driven Health Care Purchasing — Four States
72. Pennsylvania's 2007 Health Care Proposal
73. Pennsylvania's Health Care Cost Containment Council

Group 8 — Handouts for All Groups

74. Public Strategies Group (PSG) — Transforming Health Care
75. Medical Home Definition
76. Creating a Health Insurance Connector
77. Iowa Health Insurance Coverage — 6 Reports — Dr. Damiano
78. Questions Answered — Dr. Damiano
79. Roadmap for Virginia's Health
80. Hagel Health Care Commission
81. Vermont Health Care Reform
82. Washington State Blue Ribbon Commission on Health Care Costs
83. Health Policy Brief — Health Insurance and the Uninsured of Iowa
84. "Transforming health care" submitted by Co-chairperson Hatch
85. Driving Directions to Sioux City Convention Center
86. Electronic Health Record Banking — submitted by Representative Upmeyer
87. Employer-Based Insurance — submitted by Stacey Cyphert
88. Future of Employer-Sponsored Insurance — submitted by Stacey Cyphert
89. Health Care Commission Expenditures as of September 30, 2007
90. Insurance Connector — submitted by Jan Laue, Courtesy of AFSCME
91. Rural Health Study Presentation by William Appelgate

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Workforce Shortage Group
Members: Sarah Swisher, Chair
Tom Newton

Goal:
A long term goal (although controversial) is to rethink the array of occupations and who can do what and who should do what.

Problem/Real Life Example:

- There is frustration in the ability to retain those that we train, especially in the Psychiatry.

Action steps/Strategy:

- There will be a Health Care Workforce Summit on Nov. 9th, 2007, hosted by the IDPH. This Summit will act as a workgroup extension of the workforce shortage group with a wide range of experts in this field who will give recommendations to the group. Julie McMahon will provide previous studies, whitepapers, and information from other Iowa Gov agencies attending and results from written comment captured from a presurvey of invited participants at the Summit.
- There were preliminary meetings with Sarah Swisher, Tom Newton, Julie McMahon with leaders from the University of Iowa, Dr. Peter Denison (sp?) and Stacey Cyphert. Sarah Swisher also indicated that she had made an initial contact with Roger Tracey from OSEP for an initial meeting on workforce issues.
- From the Summit and from this workgroup, recommendations and action steps will be made with a focus on near term goals (1-2 years) and long term goals (3-10 years), so that forward motion is seen immediately and grows from there. Later in this discussion we will work on key questions that we will also ask and study at the summit to determine the direction.
- Stacey Cyphert presented the report of the Task Force on The Iowa Physician Workforce from January, 2007.
- Kyle Carlson, chair, Generation Iowa Committee noted that the Committee is also studying workforce issues, and noted that loan repayment/reimbursement and workforce retention always come up.
- Don't paint a rosy picture of the profession, especially for long term care workers, when a person is in training
- Look at workforce shortages and trends. For example, that generation X may have a higher tendency to move somewhere they want to live and then find a job where older generations had the job determine where they wanted to live and to take this information and look how we can use it to benefit Iowa's health care workforce shortage.
- Someone (no specific person here) would ask the Legislative staff to research what other groups (like the IDWD skilled workforce shortage committee) are out their and what they are doing and how we can, at minimum communicate even at some kind of parallel level.

There is a need for an organization plan to keep agencies and departments who work on health care workforce issues working together or at least communicating well together. Julie McMahon with the IDPH showed some examples from the South Dakota Health Care work force interagency team work flow documents and the a report on State Actions and the Health Care Workforce Crisis by the Association of Academic Health centers.

- Look at immediate fixes such as placement and then the longer term would be more of the research aspect.
- Draft legislation to address the top 5 health care workforce shortages with a formula of something like loan replacement, something for wages and other things the group decided on and that the formula legalization would stay the same just the job titles would move in and out once the need was fulfilled. There could also be a step that would put other jobs on a watch list with legislative steps to keep them off of the critical top 5 list.
- Kyle Carlson agreed to look into good language for loan forgiveness or partial loan forgiveness.
- Telemedicine was briefly discussed to address, especially mental health help in rural areas.
- Also discussed would be to look if reimbursements were truly a factor or not in retention in all of the workforce, or just some areas and if it is not to stop addressing it as through it is a factor.
- Briefly spoke about professions who do not take Medicaid patients and, for example, if they should be like lawyers who have to take on some pro-bono work that some professions should have to take some Medicaid patients, especially in the field of Dentistry.
- Reduction of licensure fees also mentioned.
- More of the detailed work will be hammered out with recommendations and a report from the Nov. 9th Summit.

Electronic Medical Records Group

Members: Representative Upmeyer, Chair
Senator Behn
Tim Kresowisk

Goal 1: Establish a permanent body to deal with electronic health records

Action steps/Strategy:

What is being done already?
What are the costs of the different components?

Goal 2: Test the interoperability of electronic health records in the IowaCare program (Broadlawns and UIHC.

Medical Home Group
Members: Representative Foege, Co-chair
David Carlyle, Co-chair
Kevin Concannon
Jay Christensen
Steve Fuller
Barb Kniff

Goal: Define medical home, dental home, pharmaceutical home, and vision home.

Action steps/strategies:

- Define Medical Home based on American Academy of Family Physicians patient-centered medical home concept:
  - Personal provider
  - Provider-directed medical practice
  - Whole person orientation
  - Care is coordinated and/or integrated
  - Quality and safety are hallmarks
  - Enhanced access to care
  - Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. Payment reflects the value of patient-centered management provided by the physician/non-physician staff that falls outside of the face-to-face visit; pays for services associated with coordination of care; supports adoption of use of health information technology; recognizes use of enhanced communication access and remote monitoring; separate fee for services payments for fact-to-face visits; recognize case mix differences in the patient population; allow providers to share in savings from reduced hospitalizations associated with provider care management; payment for measurable and continuous quality improvements. There should be accountability in the medical home--they should save resources/costs and improve quality. There should be increased reimbursement for improved quality.
  - The medical home should be integrated with the dental home, pharmaceutical home, and vision home. The medical home should also encompass behavioral health.
- Electronic records and accountability are key elements of the medical home. Grants could be provided to develop infrastructure for e-records.
- The primary care giver should be defined.
- Measurable points should be developed by department heads and others. The Department of Public Health could coordinate the effort to develop the concept unless a new agency/organization is developed to champion the effort to engage physicians, educators, private insurance, group insurance, ERISA protected plans, etc. The effort is a shared responsibility.
- Results should be demonstrable
- The Medicaid program/hawk-i/state pool could be used to pilot the medical home concept and private could buy into the medical home concept.
- There should be education, training, certification for uniform implementation.
- What are the start up costs of a pilot? What can the General Assembly do to assist?

Health Care Coverage Group

Members: Senator Hatch, Chair
Representative Hoffman
John Aschenbrenner
Susan Voss
Russ Sporer
Jan Laue
Kevin Concannon

Goal 1:

Require everyone to have a minimum standard plan that includes prevention, diagnostic, catastrophic, and general condition. Coverage should be affordable. There will be subsidy if an individual can't afford to purchase coverage. Insurance reform include true portability, eliminating pre-existing conditions, guaranteed availability, pooling and rating classifications.

Action steps/ strategy for Goal 1:

Create a quasi-public/private entity to create and administer the mandate to have such minimum insurance coverage.

Goal 2:

Leverage existing public health plans, Medicaid, hawk-i, IowaCare etc. to include more uninsured Iowans and include more providers of care

Goal 3:

Slow the escalation in health care costs:

a. Promote and assure use of evidence-based practices to be reflected in the minimum standards of the plan.
b. Control quality and cost.
c. Strong management of chronic diseases.
d. Reimburse providers more highly who reduce costs.

Goal 4:

a. Structure mandated plans that are affordable e.g. don't cost more than a certain percentage of income to consumer (5% e.g.).
b. Subsidize for person at various levels of income to reduce costs to that percentage.

Action step/strategy for goal 4:

1. Reduce the number of uninsured so that the mandate is more doable
2. Start with the most critical and most needy at the lowest cost and cover those first.

Goal 5:

Mandated minimum standard plan would reimburse health providers for medical outcomes that lead to healthier lifestyles.

Goal 6:

Recommend health commission contract for a study to determine an appropriate level of subsidy for uninsured individuals and families, e.g. sliding scale.

Goal 7:

Avail Iowa of any additional funds to achieve goals especially for help in increasing Medicare rates.

Goal 8:

Continue to support employer-based health insurance but employers that don't provide insurance to employees pay into the subsidy program. If an employer provides insurance, the employer receives a tax credit.

Purchasing pool for medications--state preferred drug list group

Members: Representative Smith, Chair
Julie Kuhle
Amy DeBruin

Goal: Establish a broad-based purchasing pool cooperative to provide savings to the consumer in order to improve the quality of health care and increase adherence to effective therapy.

Problem/real life example:

1. Adherence to medications
2. Smoking cessation
3. Use of vaccinations

Action steps/strategy:

- Use of a four-tier reimbursement for pharmaceuticals by adding a zero-co-pay initial tier. Currently there are three tiers--generic, preferred, and non-preferred. The fourth tier would be the initial tier for drugs that have been demonstrated to be effective and which decrease morbidity and mortality. This would provide a pay-back on the back end. Investigate entities that use the 4-tier approach and the cost savings.
- Statewide purchasing pool for vaccines
- Investigate private or public/private PDLs
- 340B covered entities--investigate having an analysis done (Julie will contact Jeff Lewis). Get questions answered.
- Wraparound to compliment the drugs for IowaCare expand the provider network for IowaCare.
- Look into state purchase of certain vaccines for providers--provide to anyone for free to ensure all receive and save on the backend. Pull together partners. Lowest cost provider provides the service.
- Focus on prevention and chronic care.

Patient Rights Group

Members: Senator Ragan, Chair
Representative Gayman
Eric Parrish

Goal 1: Insurance consumer advocate: Identify most common patient problems

Problem/Real Life Example:
Lack the resources to pursue consumer complaints

Action step/strategy:
Legislate for consumer insurance advocate (placement, penalties, rules to be determined)

Goal 2: Endorse four cornerstones of healthcare: interoperable health information; transparency of quality information; transparency of price information; incentives to promote high-quality and cost-effective care. (everyone endorses four-cornerstones).

Action step/Strategy:
Review United States Department of Health and Human Services four cornerstones of health care RFI/RFP. Health Buyers Alliance conference on October 24, 2007 in Des Moines.

Goal 3: Build strategies for engaging and empowering consumers. (based on universal health care)

Action step/strategy:
Promote and advocate through public health to other advocates e.g. public awareness campaigns, campaign specific to audience and need.

Funding Subgroup.

Members: Senator Bolkcom, Chair
Senator McKibben
Joe Teeling
Patsy Shors
Sharon Treinan
John McCalley

Goal: Iowa will make health insurance more affordable.

Real life story. Someone without health insurance has a heart attack…..
Or see "Sicko"

Strategies:

- Expand hawk-i so every Iowa child has insurance coverage
- Transparency on quality outcomes
- Develop pay for performance demonstration
- Disease management demonstration
- Small group and individual insurance reform legislation
- Identify centers of excellence/best practices
- Increased funding of Public Health wellness/health promotion efforts
- Strengthen certificate of need process
- Reform fee for service—pre-pay plans
- Reward healthy behavior with additional insurance reform
- Address cost shifting from Medicaid and Medicare
- Reinstate physical education requirement in K-12 schools
- Increase the use of mid-level health care practitioners
- Increase use of nurses in schools
- Create incentives for people to create "end of life" plans
- Conduct a feasibility study on allowing local governments (city county school) to buy into state employee insurance pool
- Implement electronic medical records
- Establish medical, dental and pharmacy homes
- Make insurance premiums tax deductible or refundable tax credit
- Transparency on all health care providers and medical suppliers

Revenue Sources:

- Personal contribution from uninsured
- Require free riders to pay—healthy, have resources
- Maximize federal revenues through Medicaid

- Provide demonstrated savings and innovate
- Raise tobacco tax
- Provider assessment
- Insurance company assessment
- Junk food assessment