Legislative Services Agency

MINUTES

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

December 19, 2007

MEMBERS PRESENT:

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

Representative Ro Foege, Co-chairperson
Representative Clarence Hoffman
Representative David Jacoby
Representative Mark Smith
Representative Linda Upmeyer
Mr. Joe Teeling
Ms. Sharon Treinen

Ex Officio members:
Mr. Kevin Concannon, Director, Department of Human Services
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 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 Foege called the eighth meeting of the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families to order at 9:30 a.m. on December 19, 2007, at the Renaissance Savery Hotel, Des Moines, Iowa. The meeting was adjourned at 4:30 p.m.

Review of Agenda. Co-chairperson Hatch reviewed the agenda and noted that the final report which will be presented to the Commission on January 8, 2008, will not include legislation but will instead provide recommendations and substantive background information for the General Assembly to use in its work. The co-chairpersons will ask the Commission to reach consensus on the Final Report.

Motion. Co-chairperson Foege distributed a written motion that requested that the Legislative Council approve an extension of the agreement with Mr. Bruce Feustel to pay his travel expenses to attend the final meeting of the Commission on January 8, 2008. Representative Smith moved and Representative Hoffman seconded the motion. The motion was approved unanimously on a voice vote.

II. Advisory Council Report

Health Promotion in Health Care Presentation. Dr. James Merchant, M.D., Dr. P.H., Dean, College of Public Health, University of Iowa, and chair of the Health Care Research Data Advisory Council, provided a presentation entitled "Health Promotion in Health Care." A recent study concluded that 63 percent of the increase in health spending is due to the increasing prevalence of health risk factors which are medically treated rather than prevented or improved. With regard to the primary drivers of health care costs, 50-70 percent of health care costs and premature death, illness, and disability are related to behaviors; 35 percent of health care costs are due to waste or inefficiency; and only 50 percent of high-dollar claims are predictable in any year based on the previous year. Some Commission members noted that with 35 percent of health care costs being attributable to waste or inefficiency, the Commission should look at this more closely including medical errors. It was noted that the Iowa Healthcare Collaborative is working in this area and that Iowa is doing better than the majority of other states.

An effective health care plan must simultaneously deploy a broad, population evidence-based approach; a targeted, high-risk/cost approach that is evidence-based; and decrease costs and improve health.

Personal Behaviors. Dr. Merchant described the medical costs of the "big three" personal behaviors: obesity and nutrition, tobacco, and sedentary lifestyle.

An average of 10 percent of total health care claims are directly attributable to obesity, 60 percent of Americans exceed the ideal body mass index of 25 (in Iowa the percentage is 60.2), and obesity will soon become the leading cause of death. There are also increased medical expenses and increased loss of productivity attributable to obesity. Dr. Merchant described a healthy weight program that works.

An average of 10 percent of total health care claims costs are directly attributable to tobacco, 25 percent of Americans smoke, and it is still the leading cause of death. Dr. Merchant described a tobacco cessation program that works. Dr. Merchant stated that while some say that the tobacco tax is regressive, it is instead progressive because it is an investment in better health. It was also noted that the majority of those who are still smoking would like to quit, but they need extra help.

System Challenges. Dr. Merchant described the various issues that are problematic in addressing health care. Part of the problem is that while the majority of funding is invested in health care or medical treatment, the return on the investment is poor with only 10 percent of medical treatment preventing premature deaths. In Iowa, 38 percent of the population suffers from chronic disease, 26 percent of the population is obese, 21 percent smokes, Iowa ranks 25th among the states in cardiovascular deaths per 100,000, ranks 24th in cancer deaths per 100,000, ranks 18th in preventable hospitalizations, has an increasing rate of uninsured, and the state's rank based on health status scoring dropped from 6th in 1990 to 11th in 2007. Another issue is the increase in health insurance rates which results in fewer employers offering health insurance benefits, especially small employers. Additionally, while some large employers offer wellness or disease management coverage, the majority of large employers do not, and it is an even less frequent offering among small employers. Iowa is a small employer state so the effects are even more pronounced.

Possible Solutions. Dr. Merchant suggested that the solution to the problem is promoting a culture of wellness including removing unhealthy foods in schools, improving the health of Iowa's children, encouraging more Iowans to quit smoking, encouraging physical activity for seniors, and promoting prevention efforts among Iowans. Dr. Merchant described a number of existing programs that progressive employers are using to provide an integrated and sustainable approach to total health management including the model program developed for NASA employees; the Wellmark Pursuing Excellence Program; Principal's Best in Class Wellness Program; and the Iowa Medicaid Smoking Cessation Program, preventive physical exams, and the Medicaid Value Management Program. Dr. Merchant concluded that wellness and health promotion programs are essential for all basic health care plans and should be made available to all Iowans.

Dr. Merchant recommended that an Iowa wellness and health promotion program policy support both a population-based health education and health promotion program led by the Department of Public Health in partnership with other stakeholders and that a basic wellness-prevention medical services plan should be required for all public and private insurance plans for Iowans, including any plan that the Commission might suggest through a Massachusetts connector-like entity. Additionally, Dr. Merchant recommended that the Commission recommend that the Department of Public Health and the Department of Human Services be charged to work with insurers, universities, employers, employee representatives, health care providers, and other stakeholders to develop specific evidence-based plans to meet the requirements specified for an Iowa wellness and health promotion program policy to target small employers and uninsured families.

Data Research Advisory Council Activities. Dr. Merchant distributed a list of the activities performed by the Data Research Advisory Council from the time of the formation of the Commission to the present.

III. The Lewin Group Presentation

Mr. John Sheils, The Lewin Group, presented "Modeling Health Reform in Iowa." Mr. Sheils described the Health Benefits Simulation Model that The Lewin Group utilizes and the types of results that can be derived from the model including stakeholder impacts. The majority of the key data sources that The Lewin Group uses in modeling are state-specific data that typically can be found on the Internet. Initially, any modeling begins with establishing a baseline for the state under current law, and then the model provides projections based on the proposal put forth. Mr. Sheils used the example of modeling that The Lewin Group recently completed for the state of Colorado. The Lewin Group has 35 years of experience in health care consulting and 20 years in comparative analyses of health reform proposals. Mr. Sheils noted that The Lewin Group is now part of Ingenix which is part of United Health Care.

IV. Health and Long-term Care Workforce Progress Report

Mr. Newton, Director of Public Health and ex officio member of the Commission, provided an update regarding the review of Iowa's health and long-term care workforce that was directed to be completed in legislation enacted during the 2007 Session. The department has conducted a review of the workforce, held a summit to elicit input from persons involved or interested in the delivery of health and long-term care services, and is working to coordinate the review with other initiatives. The department will submit its findings on or before January 15, 2008.

The report will include action steps to address the shortages and challenges identified. The short-term action steps (those to be completed in the next one to two years) include establishing a structure for coordination of all workforce efforts, increasing recruitment and retention, and continuing efforts to increase Iowa Medicare and Medicaid reimbursements. Long-term action steps (those to be completed in the next three to 10 years) include aligning licensure scope of practice with scope of practice taught in education programs; maximizing best practices and efficiencies in delivery of services; continuing efforts toward wellness and prevention to reduce demand; continuing efforts to increase Iowa Medicare and Medicaid health care services reimbursements; maintaining and improving workforce data systems; sustaining recruitment and retention programs that are working; and developing new programs. The department will have the final report posted on its web site by January 31, 2008.

V. Workgroup Discussions and Reports to Full Commission

Overview. The Commission members divided into their workgroups: Workforce Shortages, Electronic Health Records, Medical Home, Health Care Coverage, Purchasing Consortium, and Funding/Cost Containment/Patients' Rights. Following workgroup discussions, the full Commission reconvened to discuss the workgroup reports. Each of the workgroup reports can be accessed on the Commission's Internet page. A number of commissioners expressed concerns with the need to prioritize their recommendations and the breadth of the Commission's work. Co-chairperson Hatch responded that the workgroup reports would be provided to the General Assembly for the General Assembly to prioritize. He added that the Commission has established the priority of covering all children first, while maximizing federal resources. The commissioners

discussed the need to meld all of the reports of the workgroups together and suggest priorities to the General Assembly. It was determined that the last 30 minutes of the meeting would be used to determine a list of overall priorities for the General Assembly to consider in 2008.

Health Care Coverage Workgroup. Co-chairperson Hatch presented the report of the Health Care Coverage Workgroup. During discussion it was suggested that those requiring subsidization could receive a subsidy to purchase insurance through the exchange (the quasi-public/private entity that would be in charge of helping individuals and businesses in complying with universal health care coverage), or to subsidize insurance provided through their employer. A provision directing that public tax-supported benefit plans, such as Medicaid, be integrated into the exchange was deleted. The report suggests some considerations in determining what is "affordable" health care coverage, but the decision will be left to the General Assembly for final determination. The workgroup clarified that coverage of young adults would be up to 25 years of age rather than 29 years of age.

Some members questioned the need for a new entity to manage the insurance program and wondered if this could not be done within the existing infrastructure. Senator McKibben suggested looking at Missouri's plan for health care reform and voiced his opposition to additional bureaucracy and the idea of less choice for Iowans. He suggested that the recommendations be broken down to achievable bullet points and that the recommendations were too broad. Other members suggested determining what the necessary functions are and then determining if a new entity is needed or if the functions can fit within the existing infrastructure. Commission members voiced concerns regarding the provisions II(D)(5) and (7) relating to determining an equitable administrative cost formula and determining premiums. Following discussion, Mr. Aschenbrenner moved to eliminate the portion of II(D)(5) which reads ", which may include determining an equitable administrative cost formula," and all of provision II(D)(7). The motion failed on a vote of 11 yes, 11 no, with three members absent. The Commission then voted on the report as presented and the report was approved on a vote of 17 yes, five no, with three members absent.

Electronic Health Records Workgroup. Representative Upmeyer presented the report of the Electronic Health Records Workgroup. The recommendations include establishing an e-health council, implementing a telehealth and telemedicine proposal in 2009, implementing a fully capable e-prescribing plan for Iowa, and coordinating with the Department of Public Health's information technology workforce needs. Representative Upmeyer noted that there are some gaps in the infrastructure backbone that the Governor's Office has suggested closing. The commissioners discussed the need for some standardization within the electronic health records framework but were also concerned with state government not allowing flexibility in the market and allowing time for the system to become interoperable. Representative Upmeyer moved adoption of the report and the report was adopted on a vote of 22 yes, with three members absent.

Iowa Health and Wellness Strategies Consortium. Ms. Kuhle presented the Iowa Health and Wellness Strategies Consortium Workgroup report. The report recommended creating the consortium to agree on common principles that will guide and influence supply and demand for health care services in Iowa with the goals of providing quality health care services, increasing access, reducing disparities, and containing costs while emphasizing population health and wellness. The report also included an endorsement of health and wellness strategies for health

care payers and purchasers and strategies to contain health care costs. An addendum to the report included a recommendation that a pilot using the recommendations of the workgroup be used in a population with state-funded health benefits, as a possible implementation strategy.

Some commissioners voiced concerns that the recommendations were too specific and also questioned whether the functions of the consortium could be administered by an existing body within the Department of Public Health and whether the functions might overlap with the functions of the exchange. Ms. Kuhle moved adoption of the report. The report was approved on a vote of 18 yes, four no, with three members absent.

Workforce Shortages Report. Ms. Swisher presented the Workforce Shortages Workgroup report. The report included the following goals: Increase the number of physicians and other health care professionals living and practicing in Iowa; increase the number of psychiatric residents in the state of Iowa; create extenders for the provision of psychiatric services in Iowa by allowing advanced registered nurse practitioners (ARNP) to render psychiatric services to patients with less supervision by physicians; address workforce shortages, where appropriate, through the use of telemedicine and other technology; address workforce shortages, where appropriate, via the consideration of scope of practice changes; provide adequate and affordable health care coverage options for all health and long-term care workers; create an office and advisory council charged with conducting ongoing health workforce assessment and planning in Iowa; increase the wages of bedside care workers and direct care workers; credential the long-term care workforce in Iowa; and provide whistleblower protections for health and long-term care workers in the private, nonprofit sector.

Representative Upmeyer voiced concerns about the provision relating to allowing ARNPs to provide psychiatric services and suggested that current law should be more fully reviewed to determine if this is allowed. Representative Upmeyer also voiced concerns about the whistleblower protections provision and suggested that this provision be handled separately. Others expressed concerns relating to how the goals fit into the bigger picture of the work of the Commission, limiting increased reimbursements to only specified workers and only addressing the role of Medicaid relative to low wages, and the specificity of appropriations in the proposal. Representative Upmeyer moved to strike the proposal relating to whistleblower protections. The motion failed on a vote of four yes, 17 no, and four absent. Ms. Swisher moved to eliminate the specific appropriations in the proposal and the motion was adopted on a voice vote. Ms. Swisher moved the report as amended, and the report was adopted on a vote of 19 yes, two no, with four members absent.

Funding/Cost Containment/Patients' Rights. Senator Bolkcom presented the report of the Funding/Cost Containment/Patients' Rights Workgroup. The workgroup proposals included: increasing public health wellness/prevention/health promotion efforts; supporting healthy local food consumption in Iowa; implementing disease management initiatives; implementing end-of-life planning initiatives; requiring all providers to disclose price and performance quality; strengthening the certificate of need program; creating an office of insurance consumer advocate; and commissioning a study to determine the costs of achieving the recommendations and the potential funding sources.

Members expressed concerns relating to palliative care, strengthening the guidelines for advance directives, and funding; the difficulty in measuring quality; and the consumer advocate. Mr. Teeling recommended that proposal four relating to end-of-life planning initiatives be amended to eliminate letters "F" and "H" relating to the Uniform Health Care Decisions Act and strengthening the guidelines for advance directives. It was also suggested that the letter "D" be amended to encourage physicians and providers to consider palliative care, rather than recognizing this as a duty. The suggestions were approved on a voice vote.

There was additional discussion regarding the proposal relating to transparency. The workgroup agreed to revise the language to allow stakeholders to work toward consensus in providing transparency rather than requiring a specific means of providing transparency. The workgroup also agreed to remove any specific references to dollar amounts in the report. Senator Bolkcom moved the workgroup report as amended. The report was approved on a vote of 11 yes, eight no, two passes, with four members absent.

Medical Home Workgroup. Co-chairperson Foege presented the Medical Home Workgroup report. The proposals of the workgroup include: creating a medical home board to determine the qualifications for and to certify patient-centered medical homes; implementation and oversight provisions for the medical home; and provisions relating to providing a dental home for all children through the I Smile Program.

Members expressed concerns regarding the establishment of another entity in the state bureaucracy and the concern of adding cost to the system and questions regarding the level of specificity in the report. There are issues with the types of incentives that will work to bring providers into the medical home network and keep them involved. Dr. Carlyle noted that if the medical home concept is found to neither improve quality nor to lower health care costs, the board is required to make a recommendation regarding whether to continue the medical home concept. Co-chairperson Foege moved adoption of the Medical Home workgroup report. The report was adopted on a vote of 18 yes, one no, one pass, with five members absent.

VI. Discussion of Priorities

Mr. Feustel facilitated the discussion of what the commissioners identified as the most important first steps.

Mr. Aschenbrenner suggested beginning work on the individual mandate by commissioning a detailed study and putting an interim plan into place. The plan would begin with covering all eligible children under the Medicaid and hawk-i programs, defining the medical home and applying the concept to Medicaid and hawk-i; and working on the wellness/prevention/disease management pieces.

Dr. Kresowik suggested focusing on the coverage workgroup goals. However, he suggested that instead of focusing on covering kids, who are largely covered, the focus should be on pre-Medicare adults as the group that is hurting and addressing the needs of that population. Ms. Shors agreed that the focus should be on coverage and on workforce needs. Ms. Treinen agreed that the pre-Medicare adult population has many needs and many feel desperate without health care coverage.

Ms. Kuhle suggested a focus on chronic disease prevention and management. Ms. DeBruin voiced support for addressing chronic conditions such as obesity and smoking and promoting wellness.

Ms. Laue suggested that whatever is prioritized must be doable and affordable. She suggested starting with electronic health records and transparency, and implementing the health care coverage mandate in phases starting with covering children because near universal coverage has almost been reached for children, and then moving on to whatever group the modeling study suggests.

Co-chairperson Foege expressed support for starting with the medical home and electronic health records recommendations, covering children, focusing on prevention and wellness and obesity, and addressing issues such as behavioral health.

Co-chairperson Hatch suggested that members who would like to participate in a writers' workgroup volunteer to meet in the next two weeks to develop a first draft of the final report. He also stated that the co-chairpersons would entertain comments from members who viewed any of the recommendations as egregious.

VII. 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. Comments on Report from the Association of Business and Industry.
2. Charity Care Report by Dr. Gary Rosenthal, Center for Research in the Implementations of Innovative Strategies in Practice.
3. Iowa Hospital Association Letter.
4. The Future of Iowa's Health and Long-Term Care Workforce report published by IDPH.
5. Iowa Health Insurance Status Summary — Nonelderly Adults Split by Age Groups, Provided by DHS.
6. Iowa Health Insurance Status Summary, Provided by DHS.
7. Health and Human Services, Other Funds, IowaCare Expenditures, LSA.

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