Legislative Services Agency

MINUTES

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

January 8, 2008

MEMBERS PRESENT:

Senator Jack Hatch, Co-chairperson
Senator Joe Bolkcom
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
Ms. Patsy Shors
Mr. Joe Teeling
Ms. Sharon Treinen (via telephone)

Representative Ro Foege, Co-chairperson
Representative Clarence Hoffman
Representative David Jacoby
Representative Mark Smith
Representative Linda Upmeyer

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

II. Discussion and Approval of Commission Report

III. Closing Remarks

IV. Written Comments submitted in Response to Commission Report

V. Materials Filed With the Legislative Services Agency

I. Procedural Business

Call to Order and Adjournment. Co-chairperson Foege called the ninth meeting of the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families to order at 9:05 a.m. on January 8, 2008, in Room 103, State Capitol, Des Moines, Iowa. The meeting was adjourned at 10:34 a.m.

II. Discussion and Approval of Commission Report

Co-chairperson Hatch presented the draft final report of the Commission and moved approval of the draft final report. Representative Smith seconded the motion. Co-chairperson Hatch provided an overview of the draft final report. Representative Hoffman asked for clarification as to what the Commission was voting on. Representative Hoffman expressed concern that the members of the Commission had very little time to review the draft final report prior to voting on it. Co-chairperson Hatch noted that the draft final report does not include a draft of legislation, but will merely be submitted to the General Assembly for its review. The workgroup reports are included as attachments and only provided guidance in developing the draft final report. The draft final report does not include specifics.

Representative Upmeyer expressed her thanks for the open process used during the work of the Commission. She expressed her concern about having so little time to review the draft final report. Representative Upmeyer asked how fully funding the Medical Assistance (Medicaid) Program is defined, whether the recommendations of the insurance commissioner regarding reform are included, how the initiatives will be financed, and how will private businesses be incentivized to be involved?

Co-chairperson Hatch responded that fully funding the medical assistance program is an unknown until decisions are made at the federal level regarding the State Children's Health Insurance Program (SCHIP) and until modeling is completed. The report merely provides a road map and is a work in progress. Co-chairperson Hatch mentioned that he received a letter from the Iowa Hospital Association noting its concerns about the work of the Commission.

Dr. Kresowik stated that he would be voting "no" on the report. He said that there was nothing specific in the report that he could identify, but that he felt the Commission had failed in its mission to try to achieve affordable health care and access for Iowans, especially for populations such as the pre-Medicare adults and individuals with chronic conditions. He had hoped there would have been more time to flesh out the details and define the action steps. Co-chairperson Foege responded that the Commission is willing to continue to work on these details.

Mr. Aschenbrenner stated that he thought the Commission had come a long way. The Commission developed a vision and shared concerns. Specifying too many or too few details is always problematic depending on individual perspectives. There was not sufficient time to develop all of the specifics, but the Commission has provided a framework to be taken to the next step. Mr. Aschenbrenner did express frustration about not having a clear understanding about which information would be included in the report, and that he felt that some inappropriate information

would be included in the workgroup reports. Co-chairperson Hatch clarified that the workgroup reports are included only as appendices to the report.

Ms. Shors echoed the remarks of Mr. Aschenbrenner and stated that she always believed that the Commission's work is just an initial step. She stated, with regard to the workgroup reports, that even though not all members were involved in all of the areas, those with expertise were involved and had done their best.

Ms. Kuhle stated that the focus now is on going forward and that the Commission has provided a structure for this.

Ms. Laue noted that the issue of health care is so huge and integrates so many pieces and ideas, that she thought the Commission had come a long way in reaching its goal of providing a foundation, even if the General Assembly decides not to follow everything in the report to the letter. Ms. Laue expressed concern that even though the framework proposed is pointing the General Assembly in the right direction, she would still like to have a single-payer system. She expressed her support for the report.

Ms. Treinen noted that the Commission worked in a bipartisan fashion and received a large amount of information in a very short time. The report is a good starting point. The Commission is providing the General Assembly with information to consider, and even though everyone might not agree on every point, not moving forward would be an error. The Commission spent a lot of time on something that should have been done long ago. Ms. Treinan expressed that she had enjoyed working with all of the Commission members.

Dr. Carlyle stated that he learned that the problem is even deeper and greater than he originally thought. In addition to those who do not have health insurance, many of those who do have coverage are getting fewer and fewer benefits due to increases in the cost of coverage. Iowa has to do the best it can because if the state waits for the federal government, it might be waiting a long time. Chronic conditions and preexisting conditions should be addressed because people with these conditions need coverage the most.

Mr. Russ Sporer stated that the Commission did good work and that he did not want to be an obstructionist but would like a means to express a minority view. Co-chairperson Hatch responded that minority views would not be included in the draft final report, but could be submitted for inclusion in the minutes. Co-chairperson Hatch also noted that the co-chairpersons are seeking the approval of legislative leadership to continue the Commission through the fiscal year to allow the Commission to have input during the Legislative Session.

Senator Bolkcom noted that $2 trillion is spent annually on health care. The Commission deserves credit for talking about a number of issues including the medical home, chronic disease management, prevention and wellness, and requiring insurance. He noted a great concern with cost containment. Senator Bolkcom thanked everyone involved, including Mr. Bruce Feustel of the National Conference of State Legislatures for his assistance in facilitating the meetings of the Commission.

Representative Jacoby noted that the Commission was aiming high at the beginning and that even though the end result is not quite complete, the work of the Commission is an impressive first run.

He stated that the Commission is on the first rung of the ladder and that he had not realized just how tall the ladder is. Representative Jacoby noted that even by starting with covering children up to five years old, significant changes can be made.

Representative Hoffman voiced his appreciation for the process and his confidence in the way the Commission worked. Bold moves are needed, as well as caution in moving forward, considering changes that might come with the national elections. One key is funding the Medicaid program sufficiently to address cost-shifting. He expressed the need to do what is right for the consumer as the work moves forward.

Mr. Teeling noted that he was a bit frustrated due to the short time frame for such a large project, but the report is a great first step. With regard to the exchange proposed in the report, Mr. Teeling asked if the exchange would be in the business of selling insurance. Co-chairperson Hatch responded that, like the state role in the hawk-i Program, the exchange would merely act as a broker. Mr. Teeling also expressed concern about increasing bureaucracy. Co-chairperson Hatch responded that going forward will require cooperation from both the public and private sectors. With regard to the report, Co-chairperson Hatch noted that the writers' group tried to find consensus on the broad concepts rather than providing detail. The workgroup reports act as a reference for more detail. Mr. Teeling asked if the proposal by the insurance commissioner regarding a consumer advocate conflicts with what the report proposes. Commissioner Voss responded that although the proposals are different they are not in conflict.

Representative Upmeyer noted that many of the members had not reviewed the reports of the other workgroups until they were shared for the first time at the December meeting. She expressed concern that people would hold the Commission members accountable for information included in the draft final report, even if they might not support everything in the report. Co-chairperson Hatch responded that there is no intention to draft legislation sponsored by the Commission. The General Assembly can move forward as it chooses. The report is broad enough that any individual legislator or group of legislators can move forward on what they want and there is no attempt to identify the report as legislation that is supported by the Commission as a whole. Co-chairperson Hatch asked that the Commission consider this a broad report. Individual commissioners might not be able to support everything in the report but can support the broad concepts of the report. The General Assembly will still look to the individual commissioners to make decisions about how to move forward and the Commission will continue to be a resource for the General Assembly.

Dr. Kresowik asked that the report be viewed as more of a progress report than a final report. Dr. Kresowik moved that the word "final" be stricken so that the written work product of the Commission is just a report. Co-chairperson Hatch commented that this will just reinforce that the Commission will continue to meet and have input. Dr. Kresowik added that his rationale is to make clear that the Commission's work is merely baby steps and that nothing has been finalized.

The motion was approved on a voice vote.

Approval of the Report. Co-chairperson Hatch moved adoption of the report as amended. The motion was approved on a vote of 16 yes, 1 no, and 3 pass.

III. Closing Remarks

Co-chairperson Foege noted that states are the laboratories for health care reform, just as they were prior to federal enactment of SCHIP. By working to build relationships, the state is in a good position to move forward. The process does not end today. Co-chairperson Foege thanked the commissioners for being so faithful in their attendance, being so hard working, and participating in such a meaningful way. He noted that government is run by those who show up and it is not a spectator sport.

Co-chairperson Foege thanked Mr. Feustel for his hard work in facilitating the Commission's work and for encouraging everyone to participate. He also thanked Co-chairperson Hatch for acting as co-chairperson and for his energy and hard work, and the staff and the members of the advisory group for all of their hard work. Co-chairperson Hatch echoed Co-chairperson Foege's comments thanking everyone for their participation and hard work.

IV. Written Comments Submitted in Response to Commission Report

A. Mr. Jay Christensen, designee of the Iowa Hospital Association to the Commission, submitted written comments in a letter dated January 3, 2008, prior to the release of the Commission report. The letter is Attachment I of these minutes.

B. Ms. DeBruin, designee of the Iowa Association of Business and Industry to the Commission, submitted comments in a letter dated January 17, 2008. The letter is Attachment II of these minutes.

C. Mr. Teeling, designee of the Iowa Health Underwriters Association to the Commission, and Mr. Sporer, designee of the Independent Insurance Agents of Iowa to the Commission, submitted comments in a letter dated January 24, 2008. The letter is Attachment III of these minutes.

V. 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 ABI."
2. "Charity Care Report" by Dr. Gary Rosenthal.
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 - Non-Elderly 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.

3676IC

IOWA HOSPITAL ASSOCIATION

January 3, 2008

The Honorable Jack Hatch
The Honorable Ro Foege
Co-chairs
Legislative Commission on Affordable Health Care Plans
For Small Businesses and Families

Dear Senator Hatch and Representative Foege:

Unfortunately, circumstances beyond my control prevented me from attending the December 19 meeting of the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families. However, I believe it is important for you and fellow Commission members to understand the perspective of community hospitals from around the state relating to several of the recommendations adopted at that meeting. While the vast majority of the Commission's recommendations are positive, many range beyond the scope of the Commission's charge and several are unnecessary or even potentially detrimental to Iowa's health care system.

Particularly troubling are recommendations on the following topics:

1) Giving the Iowa eHealth Council oversight responsibility for recent federal grants awarded to the Iowa Hospital Association (IHA) and the Iowa Health System (IHS). These awards are independent grants from the Federal Communications Commission and as such do not come under the purview of state government. The focus of these awards is to connect all Iowa hospitals to a broad band network for data transmission. While eventually such a system *might* lead to the sharing of electronic medical records, the grants as they stand today are merely for infrastructure costs associated with network connections. No state activity is warranted in this area except to perhaps provide additional funding to incent all hospitals to connect into the network.

2) Requiring disclosure of estimated payments from health care providers. As presented to the Commission, the Iowa Hospital Association already provides hospital charge information on all inpatient services, with outpatient services to be added in 2008. IHA and community hospitals support price transparency in health care and are voluntarily leading this effort; however, price transparency must extend to other entities in the health care arena, including insurance companies and medical suppliers, before any mandates upon community hospitals should be considered.

3) Mandating quality reporting standards from health care providers. Again, this is an unnecessary recommendation given the outstanding work of the Iowa Healthcare Collaborative in providing meaningful quality data in Iowa. The Iowa Healthcare Collaborative is uniquely positioned to make determinations about the best quality measurements to report, has the full cooperation of the Iowa health care provider community,

is recognized nationally for its leadership, and is supported in part with a state appropriation. To abandon the work of this organization and mandate potentially meaningless data to the general consumer could dismantle this voluntary effort and actually slow the commitment by Iowa providers to be transparent in quality initiatives. Furthermore, this disregards the quality improvement efforts initiated by the Iowa Healthcare Collaborative based upon the data collection, which would not be duplicated by a state mandate.

4) Strengthen the certificate of need (CON) process. This recommendation has little to do with the charge of the Commission and seems to be a response to recent hospital activity in the Des Moines market. Not only is there currently judicial action pending on this topic which would provide the General Assembly with greater clarity, but the last time CON changes were contemplated (in the late 1990s) the legislature established a separate commission that met over several months to discuss all the nuances of the CON process…indicating that changing CON is a more complicated question than is recognized by this recommendation.

5) Mandating health care whistleblower provisions. It has long been the position of the Iowa Hospital Association that Iowa health care workers already have multiple legal protections when bringing forth patient safety concerns. This issue has been debated in the Iowa General Assembly in separate legislation for the past several years. This recommendation has nothing to do with the cost of insurance for small businesses and families, but rather reflects the position of a limited constituent group. Unnecessary language in this regard may only make it more difficult for employers to discipline health care workers who provide substandard care.

6) Directing Medicaid provider payment increases to nurses. While this is a laudable goal, information provided to the Commission by IHA staff clearly indicated that Medicaid increases have lagged well *below* the rates of nurse salary increases in hospitals since the year 2000. Aiming Medicaid provider rate increases toward nurses also ignores all the other clinical specialties, including physicians, who are currently in short supply in Iowa. Medicaid certainly provides a vehicle for addressing the uninsured in Iowa, but not in this regard. In fact, there is no more meaningful action the state of Iowa could take to minimize the cost-shift of insurance to small businesses and families than to *fully fund its Medicaid program*, both in terms of provider payments and beneficiary enrollment.

7) Assessing fees on health care providers. This is a short-sighted recommendation as a way to raise funds. Any additional costs imposed upon providers will necessarily raise health care costs, including insurance costs for small businesses and families.

The Iowa Hospital Association Board has been evaluating the Commission work over the past several months and is prepared to offer the following policy recommendations that should move the Commission closer to the goal of meeting its charge than things such as those mentioned above. These include:

1) Invest directly in Medicaid. As previously mentioned, this includes maximizing beneficiary eligibility and provider payments. While this is not an inexpensive proposition, Medicaid investments are matched nearly 2-to-1 by the federal government, making this a more cost-effective strategy than creating a new insurance pool financed by state dollars only.

2) Enroll all eligible children in Hawk-i and Medicaid. As the Commission has noted, additional outreach efforts for these programs could raise the number of insured children in Iowa to virtually 100 percent.

3) Expand family insurance coverage to include young adults to age 25. This not only impacts young adults who have insurance options but choose not to accept coverage, but also positively impacts Iowa's Medicaid program. Approximately 40 percent of all Iowa births are now Medicaid-eligible. Expanding family coverage would keep many of those mothers off the Medicaid rolls.

4) Apply mandates for insurance coverage only to those who have a means to pay. Instead of a costly and administratively burdensome new system trying to achieve universal coverage, any individual mandates to buy health insurance should be directed only to those Iowans with sufficient income levels to pay. In this manner, tax penalties such as those used in other states might actually influence behavior (as tax incentives/penalties are less effective with the poor) and could prevent Iowa from going down a state budget-busting path (such has been the recent experience with an individual mandate in Massachusetts). Building upon Medicaid, expanding family insurance coverage, and aiming any insurance mandates only upon the wealthy would address Iowa's uninsured population from three meaningful angles, while allowing the state to better manage its budget.

5) Develop a Medicaid payment system that rewards value. The experience of other states demonstrates that a punitive pay-for-performance system does *not* work, especially in a state like Iowa where most providers are already at the high end of the quality rankings. But recognizing value through payment incentives can have system-wide impact on a collaborative health care system such as the one we enjoy in our state.

6) Support provider-led pilot projects that demonstrate savings. Providers already are developing chronic disease management programs and other cost-saving initiatives. However, most insurers, including Medicaid, do not reimburse for such services. The state should create financial incentives for providers who can demonstrate health care savings to recoup a portion of those savings.

7) Support a statewide emergency mental health treatment alternative. The Department of Human Services is currently working on such a model. Development of a system that can help divert acute mental health patients from the hospital emergency room is critical for Iowa, where the lack of psychiatrists is hampering the ability to provide hospital inpatient behavioral health services.

8) Create a more standardize county mental health service delivery system. Iowa's behavioral health care providers currently have to contend with 99 different sets of benefits and payment structures from 99 different counties. Iowa should establish a core set of behavioral health services that all counties must adhere to in order to provide equity across the state.

Iowa's community hospitals certainly appreciate the hard work of all Commission members to address Iowa health care concerns. However, as identified a the beginning of this process, Iowa is starting from a position of strength rather than a position of weakness when it comes to providing high quality, affordable health care to our citizens. The wide-ranging recommendations embraced by

the Commission on December 19 in some respects fail to recognize that position of strength and go beyond the scope of our collective deliberations. As the Commission prepares for its final meeting and report review January 8, I urge you to more narrowly focus our recommendations so that the full General Assembly can evaluate meaningful health care strategies that do not violate the Commission's own principles…that recommendations should be sustainable and should do no harm.

I appreciate your attention to these highlighted issues.

Sincerely,

Jay Christensen
Chairman, Iowa Hospital Assocaition

cc Governor Chet Culver
Senate Majority Leader Mike Gronstal
Senate President Jack Kibbie
House Majority Leader Kevin McCarthy
Speaker of the House Pat Murphy
House Minority Leader Christopher Rants
Senate Minority Leader Ron Wieck
Members of the Commission on Affordable Health Care Plans for Small Businesses and Families

The Voice of Iowa Business Since 1903.

January 17, 2008

Senator Jack Hatch
Representative Ro Foege
Co-Chairs
Commission on Affordable Health Care Plans

Dear Senator Hatch and Representative Foege:

Please know how honored I am to be part of the Commission on Affordable Health Care representing the Iowa Association of Business and Industry. Being part of the Commission over the past eight months has been a challenging and an extremely rewarding experience. I want to thank you both for your leadership in this endeavor.

As you know, when the Commission met on January 8, 2008, for the last time prior to the Legislature convening its 2008 session, the Commission voted to approve a Report full of recommendations and policy ideas. In my capacity as a representative of small employers in Iowa I was pleased to vote in favor of the Report as I believe it represents the majority of ideas and proposals that the diverse Commission members could reach consensus on. Those policy recommendations also present the best roadmap for achieving better health for our citizens and containing costs for insurance purchasers.

There were a multitude of other issues that the Commission and the various work groups discussed that were contentious and could not be agreed upon by the various interests represented on the Commission. It is my understanding from you that those policy items are not to be considered as part of the report, but rather are simply a part of the Commissions work record. Please advise me if I am not correct in my understanding.

While I was pleased to vote in favor of the report as presented on January 8th, I feel it is necessary to express specific concerns regarding a couple of items contained in the Report.

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- Creation of Health Care Exchange

We have concerns about this specific recommendation for several reasons, the first of which is that it creates another government entity manage health care insurance. Iowa already has an Iowa Insurance Division of the Department of Commerce and creating a new bureaucracy will be duplicative and costly to taxpayers.

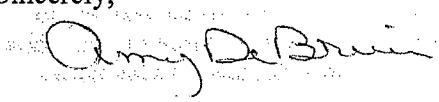
Additionally, this concept appears to be similar to the "Connector" utilized in Massachusetts. The Massachusetts Connector collects 4% of premium off the top – that must be passed on to consumers as additional cost to the consumer.

- Creation of Office of Health Care Insurance Consumer Advocate

Instead a creation of another government agency work on behalf of consumers, we would suggest serious consideration be given to existing proposals that add a consumer-focused personnel to the Iowa Insurance Division of the Department of Commerce. Such a proposal would be more cost effective and protect taxpayers from funding another government bureaucracy.

It is my desire that this letter be made part of the Commission record. Thank you again for your leadership of the Commission. Please let me know if I can be of further help or assistance to you or the Commission.

Sincerely,



Amy DeBruin, PHR
Executive Vice President and
Human Resource Manager
Interpower Corporation

January 24, 2008

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

There are two provisions within the Commission's report to which we would like to express our concerns.

First, we believe the "insurance exchange" is not necessary for the purposes the report appears to imply. Today, in virtually every town and city in Iowa, there are local insurance professionals who provide Iowans access to health insurance. We believe the exchange will unnecessarily duplicate these services. The term "exchange" appears to create an expectation that a sales and marketing system for health insurance access will be created. This concept appears to be similar to the "Connector" utilized in Massachusetts which creates additional governmental bureaucracy. As happened in Massachusetts, this will add cost to health insurance premiums and, as premiums increase, uninsured numbers also increase. This is quite simply counterproductive to the original goal and objective of the Commission which was to address the affordability and accessibility of health insurance. This duplication of marketing and sales is not needed, and we believe centralizing these functions does not serve Iowans fairly. Access points to secure insurance quotes by Iowans are not currently a problem in the state, and an insurance exchange is a move which undermines hundreds of small businesses who provide this advice and service in virtually every community in the state.

The second issue of great concern is the "insurance advocate." Iowa has a strong and competitive insurance industry. Iowa has been viewed as the state other states strive to be more like, and our regulatory climate creates some of the fairest priced insurance products in the nation. Hundreds of companies call Iowa home and choose to because of our fair and evenhanded regulation. If the legislature is convinced an "insurance advocate" for consumers should be established, it should be within the Iowa Insurance Division. Regulation of insurance products, sales, rating and claims service should solely be the responsibility of the Insurance Division.

Iowa should note that when other states choose to overregulate the insurance industry, prices go up and competition retreats. It is our belief that it would be a serious mistake to implement a health insurance sales exchange, or create an office of insurance consumer advocate if the office is not within the Iowa Insurance Division.

On behalf of:

Iowa Health Underwriters Association

Joe Teeling

Independent Insurance Agents of Iowa

Russ Sporer, CPCU