MINUTES

Legislative Health Care Coverage Commission

October 20, 2009

MEMBERS PRESENT:

David Carlyle, Chairperson
Ted Williams, Vice Chairperson
Mike Abbott
Amy Logsdon (alternate for Betty Ahrens)
Jennifer Browne
Diane Crookham-Johnson
Joan Jaimes
Bruce Koeppl
Marcia Nichols
Tim Stiles
Erik Kuhlsdorf (alternate for Joe Teeling)
Senator Jack Hatch
Representative Mark Smith
Representative Linda Upmeyer
Director Tom Newton
Angela Burke Boston (alternate for Commissioner Susan Voss)

MEETING IN BRIEF

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

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

I. Procedural Business

The meeting was called to order at 10:07 a.m. and was adjourned at 3:00 p.m. The members approved the minutes of the September 9, 2009, meeting.

II. Presentation by Representative Sharon Anglin Treat — Dirigo — Lessons Learned in Maine

Overview. Representative Treat, Maine, provided information regarding Maine's model for health reform, Dirigo, enacted in 2003. Representative Treat noted that the three goals of Maine's health reform are: controlling health care costs, improving quality, and expanding access to health care coverage. Although there was "grudging" support during the legislative process and the final product has its shortcomings and has encountered challenges, the initiative provides lessons for state and federal health reform efforts.

Dirigo Summary. The legislation enacted to implement Dirigo consisted of an expansion of MaineCare, the state's Medicaid program, to provide coverage for parents of Medicaid-eligible children up to 200 percent of the federal poverty level (FPL) and coverage for childless or noncategorical adults up to 100 percent of the FPL; creation of DirigoChoice, Maine's version of a public/private option, offering a subsidized insurance product to provide coverage to Maine's uninsured employees of small businesses, the self-employed, and individuals with incomes up to 300 percent of the FPL, based on a sliding scale and for those with incomes above 300 percent of the FPL at cost with no subsidy; and reforms aimed at containing the rate of growth in health care costs, promoting public health, improving quality of care including the Maine Quality Forum, beefing up the certificate of need process, and instituting health insurance regulation reform.

Representative Treat provided examples of how Maine's health care reform efforts have played out. Initially, the legislation included provisions to control spending by providing hospital incentives to operate more efficiently and effectively. The legislation established global budgeting to set limits on hospital spending, proposed a mechanism for better coordination and planning by hospitals, and sought to increase certificate of need provisions to regulate investment in new technologies and facilities by hospitals. In the end, only the certificate of need measures were included in the final version of the legislation.

Public/Private Coverage. With regard to administration of DirigoChoice, the public/private partnership to provide publicly subsidized insurance, the Dirigo Health Agency, an independent agency with a board of directors, utilized a request for proposals process to select a private partner. However, the consolidation of the insurance market in Maine through the departure of several nonprofit insurers in the 1990s left only the for-profit Anthem Blue Cross Blue Shield, which controlled over 70 percent of the insurance market as the sole initial bidder to provide insurance. Additionally, the subsidy was provided through a convoluted process utilizing a complicated subsidy calculation and rebates rather than up-front payments. After these initial challenges, however, the changes in the enrollment process were made and beginning in January 2008, Harvard Pilgrim Health Care, a nonprofit organization, began partnering with the state to provide health insurance coverage through DirigoChoice. The policies offered are comprehensive, not bare-bones policies, and focus on wellness and preventive services.

Financing. In Maine, unlike in Massachusetts where that state utilized an existing uncompensated care pool of funds to finance its health care reform, financing was problematic. Initially, Dirigo was to be funded through a 4 percent assessment on gross revenues of health insurance companies, based on the argument that their rates reflected costs that Dirigo would eliminate from the system, such as costs associated with inefficient delivery of care, overutilization of services, bad debt, and charity care. So, rather than allow insurers to retain profits that resulted from these savings, the assessment would be collected and used to pay for the reforms. Insurers protested, and the flat assessment was replaced with a variable assessment, calculated annually and based on annual savings as approved by the Superintendent of Insurance. The assessment or Savings Offset Payment (SOP) created a protracted process that costs approximately $1 million annually, and involves the Dirigo Board, the Superintendent of Insurance, and usually ends up in court to resolve. This process has undermined the predictability and amount of funding for Dirigo. In 2008, legislation was passed to replace the variable assessment with a flat assessment of 1.8 percent and impose a dedicated beverage tax. However, the law was overturned through a referendum. In 2009, legislation was enacted to replace the SOP with a 2.14 percent surcharge on paid claims. The assessment is projected to raise $42 million annually, which is sufficient to maintain existing participation levels in DirigoChoice.

Outcomes. Despite the challenges, Maine's health care reform efforts present some successes and lessons learned. Successes include that in 2002 Maine ranked sixteenth among all states in the lowest level of health insurance coverage. In 2007, Maine ranked fourth nationally in highest rate of health insurance coverage, providing 25,000 more Mainers with coverage through expansion of Medicaid and DirigoChoice. Additionally, 700 small businesses and nonprofit organizations have utilized the options to provide insurance for their employees who were either uninsured or underinsured. Premium increases of 13.2 percent annually, from 2001 to 2003, were reduced after Dirigo was enacted to only 6.4 percent between 2004 and 2006. This change was tied, in part, to an agreement with insurance companies to voluntarily limit profits to 3 percent for the first year after passage of Dirigo. However, this provision has not been renewed, and premiums are once more increasing. Another success is the Maine Quality Forum (MQF). The MQF collects data regarding how medicine is practiced in the state and utilizes the data to perform studies to achieve savings and improve quality; provides information on best practices and works with providers to improve performance, reduce costs, and improve quality; and facilitates initiatives and pilot projects to improve coordination and delivery of care for patients. Dirigo also requires the Governor, along with the citizen and stakeholder Advisory Council on Health System Development, to issue a state health plan every two years to provide a roadmap for future actions.

Discussion. In response to questions from the members regarding funding, Representative Treat noted that in Maine there were many suggestions, but they did what was politically feasible. Some reforms that could move toward sustainability such as the medical home, payment reform, and other insurance reforms are just now being implemented. Affordability and portability are important. In Maine they discussed which insurance reforms to implement if additional funding is available. Representative Treat suggested that in insuring specific populations, such as young people, an actuary might be useful in providing options. In response to a question regarding any stigma associated with accessing health care coverage through Dirigo, Representative Treat noted that because Dirigo is all one program with one card, the stigma of having no-cost or subsidized

coverage does not seem to be an issue. With regard to how national health reform will impact Dirigo, Representative Treat said the state is in a wait-and-see mode, but that if a more robust public option is provided, Maine might redesign its program.

As the Executive Director of the National Association on Prescription Drug Prices, a nonpartisan organization of state legislators working jointly to reduce prescription drug prices and expand access to medicines, Representative Treat also provided information regarding academic detailing and the federal 340B program in addressing pharmaceutical access, quality, and cost issues.

III. Federal Health Reform Update

Representative Treat and Senator Hatch, both members of State Legislators for Health Reform, a group of state legislators from across the county established to advise the White House in its health reform efforts, provided an update on national health care reform. Senator Joe Bolkcom and Representative Mark Smith are also members of the group.

Senator Hatch noted that during the previous week, over 30 of the legislators involved in the group participated in a two-day lobbying effort, meeting with 35 congressional offices, mostly "blue dog" democrats, to discuss inclusion of a public option in national health care reform. They also spent two hours at the White House and feel that there will be a robust public option unless resisted by the insurance companies. The most important element of the legislator involvement is that it is not a partisan debate. All legislators, both Republican and Democrat, are trying to gauge how national reform will impact their states. Some states are still working on their current fiscal year budgets and realize that there are no good solutions for dealing with funding. Senator Hatch stated that Congressional Democrats are still reaching out to Congressional Republicans and are hopeful that more will get involved in the details of reform.

Representative Treat added that legislators are providing the practical information to the White House and members of Congress that is necessary to facilitate implementation. The details are important. Being from Maine, she is proud of Senator Olympia Snowe's support of the Senate Finance bill and noted that Senator Snowe is not the only Congressional Republican interested in reform.

IV. Health Coordinator Update

Ms. Anne Kinzel, Health Coordinator for the Commission, distributed a document regarding Iowa-specific employer-sponsored insurance coverage developed by the Urban Institute and the Kaiser Family Foundation based on the March 2008 and 2009 current population survey. She expressed her satisfaction with the efforts of the workgroups to date, noting that even though there is still much ambiguity regarding the details of national health care reform, the work of the Commission will help to better position the state for whatever develops nationally, as well as keep the state moving toward options in covering those who remain uninsured.

V. Updates From Workgroups — Workgroup Meetings

A. Workgroup 1 (WG1) — Coverage of Adults

Chairperson Carlyle presented the report for WG1 noting that WG1 met in person on September 28, 2009, and by conference call on October 12, 2009. On September 28, WG1 received information on IowaCare and the hawk-i program, and on October 12, WG1 discussed options to improve or expand IowaCare. The report includes major discussion items including the complexity and limitations of IowaCare; the need to integrate whatever federal changes are made into any continuation of IowaCare; IowaCare should continue as a stopgap until federal reforms are actualized; additional federal funding could be used to shore up the existing IowaCare program; expansion of IowaCare could include regionalization and collaboration with other safety net providers; a start to regionalization of IowaCare could be a diabetic registry program for IowaCare patients or patients accessing other safety net providers; future steps would include discussions with current IowaCare providers and potential future providers; and positioning Iowa for any national reform is a necessary next step for WG1. Other members noted that WG1 also needs to look at options for those at higher income levels such as the hawk-i program.

B. Workgroup 2 (WG2) — State Pooling

Mr. Stiles presented the report for WG2. WG2 had two meetings on September 29, 2009, and October 8, 2009. During the first meeting, WG2 received testimony from small employers, schools, municipalities, and nonprofit organizations regarding the lack of affordability of health insurance. He noted that providing health insurance to employees helps employers to retain good talent and maintain service quality. Many employers are experiencing double-digit growth in their health insurance premiums and the majority budget 10-15 percent of their operating budgets for this item. It is frustrating when funding for nonprofits cannot be used for direct services because operating costs are so high.

On October 8, 2009, WG2 received information from representatives of the insurance industry regarding cost curves and pooling options. The industry recommended that the only way to "bend" the cost curve is to address chronic conditions and prevention. While there have been attempts at pooling by various groups, they have usually failed because of the "death spiral" which is a phenomenon in which the healthier individuals in a group leave due to cost or other issues, and only the high-risk individuals are left, causing rates to increase to an unaffordable level. Other issues include whether to make inclusion in a pool mandatory, the benefit plan to use, and the idea that it is not the size but the composition of the pool that is important. WG2 plans to hold additional meetings during which representatives of groups that have formed pools will provide information. WG2 will also receive information through Ms. Kinzel on the Connecticut pooling approach which was passed and vetoed twice, but is instructive as to working with the various interests including unions.

C. Workgroup 3 (WG3) — Administration of Health Care Reform

WG3 Chairperson Williams provided the status report for WG3. WG3 met once on October 15, 2009, to address the question presented by Chairperson Williams: "If federal health care reform includes an individual mandate and an exchange to assist Iowans in selecting coverage, what

recommendations would the Commission make to prepare the state for this?" Members received information regarding insurance exchanges, individual mandates, and health reform efforts in Massachusetts. WG3 members developed a listing of issues that need to be addressed in developing an exchange and will continue to work through these issues.

D. Commission Discussion

A number of members expressed the need to address cost in the deliberations of the workgroups. Senator Hatch agreed that the workgroups should address cost, but should not be constrained by limitations in revenue which is more appropriately the purview of the General Assembly. Representative Smith stated that he was impressed by the efforts of the workgroups and the consideration given to various viewpoints as they identify problems and solutions. Representative Treat commented on each of the workgroups.

- **WG1 — Coverage of Adults:** She noted that some initiatives, such as a disease registry and working on chronic conditions, are things that states can and should do regardless of what federal health reform brings. Vermont is an example of moving forward in this area with very little funding.
- **WG2 — State Pooling:** She noted that developing pools utilizing the state employee pool often meets with resistance, but analyzing the concept could be beneficial.
- **WG3 — Administration:** The workgroup needs to look at various models to see what has been shown to work. If federal reform includes an exchange, the states that have a mechanism in place will have an advantage.

E. Workgroup Meetings — Next Commission Meeting

Commission members divided into their respective workgroups for discussion. Upon reconvening, workgroup chairpersons reported the dates for future meetings:

- WG1 — November 9 and 23, 2009
- WG2 — November 18, 2009
- WG3 — To Be Announced

Additional information regarding the workgroup meetings is available on the Commission website. The next meeting of the Commission will be held on December 2, 2009, in room 103 of the Capitol from 10:00 a.m. to 3:00 p.m. and will include a presentation by Mr. David Lind on his recently completed employer benefits survey.

VI. 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 web page: http://www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=484.

1. A Template for Establishing and Administering Prescriber Support and Education Programs from Representative Treat.

2. Academic Detailing — At a Glance from Representative Treat.
3. Choices, Quality Affordable Health Care: A Work in Progress, A Window of Opportunity — Maine Center for Economic Policy.
4. Employer Sponsored Insurance Coverage from Ms. Kinzel.
5. LD 1264 — 2009 Changes to Maine Dirigo Program — from Maine State Representative Treat.
6. Maine State Representative Treat's Biography.
7. Mission Summary of Workgroup 1 — Coverage of Adults.
8. National Health Reform — Lessons from Maine — Maine Center for Economic Policy.
9. Status Report from Workgroup III — Administration of Health Care Reform in Iowa.

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