MINUTES

Legislative Health Care Coverage Commission

December 2, 2009

MEMBERS PRESENT:

David Carlyle, Chairperson
Ted Williams, Vice Chairperson
Mike Abbott
Betty Ahrens
Jennifer Browne
Diane Crookham-Johnson
Joan Jaimes
Bruce Koeppl
Marcia Nichols
Tim Stiles
Joe Teeling
Senator Jack Hatch
Senator David Johnson
Representative Mark Smith
Representative Renee Schulte (alternate for Representative Linda Upmeyer)
Lynn Patterson (alternate for Tom Newton)
Commissioner Susan Voss
Jennifer Vermeer (alternate for Charles Krogmeier)

MEETING IN BRIEF

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

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I. Procedural Business

II. Federal Health Reform Update

III. Iowa Employer Benefits Study

IV. Workgroup Reports

V. Materials Filed With the Legislative Services Agency

I. Procedural Business

The meeting was called to order at 10:00 a.m. and was adjourned at 3:00 p.m. The members approved the minutes of the October 20, 2009, meeting. The members voted to suspend the rules to allow Representative Schulte to act as an alternate for Representative Upmeyer during the meeting.

II. Federal Health Reform Update

Chairperson Carlyle asked that each of the legislative members of the Commission comment on national health care reform efforts.

Representative Smith noted that the State Legislators for Health Reform, a group of state legislators from across the country established to advise the White House in its health reform efforts, of which Representative Smith, Senator Hatch, and Senator Joe Bolkcom are members, has ongoing conference calls and is currently focused on how states would implement the reform measures, including the issue of a public option. Reform is still in the early stages, but the group is monitoring the process and providing input from the states' perspectives.

Senator Hatch noted that it is clear that the federal debate will go on for some time and that the results will affect the states' ability to provide better health care.

Representative Schulte commented that the main concerns of Republicans are the cost of health care reform to the states, how states will pay for it, whether citizens will be taxed to cover the costs of reform even before they have coverage, and the need to address medical cost issues.

Senator Johnson added that the concern is not just cost, but the policy issue of one size not fitting all states, and the need for federal reform to allow for flexibility. Iowa has done good work as a state in moving forward on health care reform and each of the sovereign states should be provided this flexibility. Members of Congress are still not in agreement and there is still no bill to review. The Iowa General Assembly is on a fast track this session and there is concern about how national health care reform will affect state deliberations.

Mr. Abbott added that the health insurance industry is supportive of national health care reform efforts, but they must include measures to "bend the cost curve," i.e., lowering costs over time and slowing the growth rate.

Senator Hatch noted that while the federal House and Senate bills are different, there are provisions in both to increase the federal poverty level income eligibility limits for Medicaid, and states will have to monitor this and determine when to expand in order to maximize federal cost sharing. There are many issues involved, including insurance reform, cost containment, and consumer protection, to name a few. States need to proceed with reform in order to be in a better position when federal measures are implemented. Senator Hatch noted that while there are cost containment measures in the health reform bills, there is also cost shifting, such as the shift from uncompensated care which results in more coverage provided through the private market. The White House group of legislators is strong in its concern about costs to the states and is mindful that with the economic downturn the number of people that need the states' help is on the

increase. States are not only closely monitoring the costs, but are also concerned with providing for the health, safety, and security of citizens.

III. Iowa Employer Benefits Study

Presentation by Mr. David Lind. Ms. Anne Kinzel, Health Commission Coordinator, introduced Mr. David Lind, David P. Lind and Associates, LC, (DPL&A), noting that 2009 is the 11th year that DPL&A has completed an Iowa Employer Benefits Study. This year the study is especially remarkable because it includes data from employers with two to nine employees known as "micro" employers. The report provides data on the realities that employers and employees face.

Mr. Lind stated that DPL&A acts as an advisor and advocate for clients who want to make informed decisions about their benefit plans, and does this by assisting employers with the planning, management, acquisition, and compliance aspects of benefit plans.

Employers are concerned because health insurance premiums have become such a big issue and employers want to know how they compare with other employers. DPL&A hired Data Point Research, Inc., to conduct the research. In 2000, DPL&A began conducting the study statewide, and comparing the data over time demonstrates a very somber trend of increasingly higher rate increases. In 2009, 892 Iowa employers responded to the survey. This compares with a Kaiser Family Foundation study in which 2,054 employers were surveyed nationwide, with 607 employers responding in 12 states. DPL&A welcomes suggestions from interested parties regarding survey questions, and based on a suggestion from Senator Hatch, the 2009 survey included the micro employers. Mr. Lind encouraged Commission members to submit questions to improve the survey in future years, noting that in addition to legislators, the University of Iowa College of Public Health has provided valuable assistance.

Mr. Lind explained his PowerPoint which highlighted some of the results of the 2009 survey pertinent to the work of the Commission. His presentation is available on the Commission's website.

- Mr. Lind reviewed the population characteristics of the employers surveyed, noting that there are 135,561 micro employers, 560 of which were sampled, and 156 of which completed interviews.
- In 2009, 83.7 percent of all employers surveyed offered health insurance benefits, with 53.7 percent of the micro employers offering benefits and 100 percent of employers with 1,000 or more employees offering benefits. From 2000 until 2009, 100 percent of the largest employers have consistently offered benefits, while the percentage of smaller employers offering benefits has fluctuated slightly. Employers with 10 to 19 employees have only been surveyed since 2005.
- The percentage of health insurance rate changes between 2008 and 2009 has only increased slightly, and the average increase overall in 2009 is 11 percent, with the highest increases being for the smaller employers. However, Mr. Lind noted that since the survey was completed, rate changes have increased from the midteens to 40 percent or greater in some cases. If data is broken out to compare urban and rural employers, both rural and urban rate change increases are near 11 percent. However,

there is a difference when the data is broken down by number of employees, with those with less than 250 employees having average health insurance rate increases of 12.4 percent compared with average increases of 8 percent for employers with 250 employees or more.

- In comparing data from Iowa Workforce Development on weekly wage increases and average premium increases, premiums have increased two to three times the rate of the wage increases over time. Wage increase data for 2009 will not be available until 2010.
- If all employers are sampled for all types of health care plans, the weighted average of a single premium for an employer and employee shares combined in 2009 is $370, with the combined premium for micro employers being $413 and for employers with 1,000 or more employees being $383. Micro employers pay the lowest amount in employer share at $54 a month compared with all other sized employers.
- The weighted average of family premiums in 2009 with employer and employee shares combined was $963. The combined family premium for micro employers was $1,024, with the employee paying $271 and the employer paying $753.
- With regard to plans under section 125 of the Internal Revenue Code, only 20 percent of micro employers have section 125 plans and only 11 percent offer medical/dependent flex plans. In comparison, 90 percent of the largest employers offer section 125 plans and 93 percent offer medical/dependent flex plans. Many employers may not be aware of the benefits of section 125 plans. The employer merely has to have a section 125 plan in place so the employee contributions can be made with pretax dollars. Flex plans are a bit more complicated and sometimes require hiring someone with expertise to administer them. Section 125 plans are a benefit that employers can provide that is not available to the self-employed. More education is needed for employers and insurance agents and brokers to understand the benefits of the section 125 plans. State legislation was enacted a few years ago to direct the Insurance Commissioner to assist employers with 25 or fewer employees with implementing and administering section 125 plans.
- The average increase in annual premiums between 1999 and 2009 for single coverage was 115 percent and for family coverage 110 percent for all plans. If the family premium average increase of 10.3 percent is extrapolated forward to 2019 (without any benefit plan changes), the annual premium will be over $30,000 for family coverage at that time.
- Since 2000, the annual medical contribution for single coverage has increased for employees by 66 percent, for employers by 92 percent, and in total premiums by 87 percent. Similarly, the annual medical contribution for family coverage since 2000 has increased for the employee by 77 percent, for the employer by 105 percent, and the total premium increase has been 95 percent.
- Due to the health insurance premium increases, employers have incorporated many strategies to address costs. Those strategies reported in 2009 for all employers include that 60 percent passed some or all of the increased cost to employees, 26 percent raised deductibles, 18 percent absorbed the entire cost, 17 percent raised the out-of-pocket maximum, and others increased copays, changed carriers, reduced raises or bonuses, delayed capital improvements, started wellness or disease management

programs, or took other actions. Surprisingly, only .1 percent stopped providing health insurance coverage. The data also provides percentages for each strategy for micro employers, with 0 percent of these employers eliminating coverage for employees. In response to an inquiry, Mr. Lind stated that he does have more specific data regarding the characteristics of employees who choose to enroll in health plans that are offered and will provide this to the Commission.

- Mr. Lind provided deductible and contribution data for Preferred Provider Organizations (PPO)-only coverage and also all plan type coverage, because until 2004, PPO coverage was segmented out. For PPO single coverage from 2000 to 2009, employee deductibles increased by 256 percent and contributions by 77 percent. For PPO family coverage from 2000 to 2009, employee deductibles increased by 256 percent and contributions by 89 percent. In 2009, the weighted average for all plans for deductibles was $1,061 for single coverage and $2,230 for family coverage. For micro employers, the deductible amounts were $1,233 for single and $2,622 for families. One concern, especially with employees of small employers, is underinsurance. With lower wages and higher copays and deductibles, there is a greater affordability gap.
- With regard to prescription drug copays, the data demonstrates that between 2000 and 2009, copays for PPOs have increased for generics by 58 percent, preferred drugs by 114 percent, and nonpreferred drugs by 87 percent. Even though there have been increases overall, generic copayments have stabilized at about $11. With regard to vision coverage, overall 35 percent of employers offer vision coverage, with only 3 percent of micro employers offering this coverage.
- With regard to offering wellness initiatives, smaller employers are not embracing this trend as quickly as larger employers. Larger employers also are more likely to offer incentives to encourage healthy behaviors, with 31 percent of the employers with 1,000 employees and 32.4 percent of employers with 250-999 employees offer this benefit, but only 12.3 percent of employers overall offering this benefit. Nearly 70 percent of employers overall reported that they were very unlikely to offer incentives for healthy behaviors in the coming year.

Discussion. In response to a question regarding what the costs reported by employers include, Mr. Lind stated that employers are asked what rate they use for budgetary purposes so this includes all costs including claims, administration, and reinsurance.

As to why health care coverage costs are increasing, Mr. Lind responded that health insurance costs are a derivative of health care costs. Policies can be instituted to make small changes, addressing such issues as administrative costs, but the preponderance of the equation is underlying health care costs. The increases in health care costs are attributable to inefficient delivery, increased utilization, and cost-shifting. This is a distraction for employers trying to run a business.

With regard to response bias, Mr. Lind noted that this is always a concern and they follow up with those surveyed. The micro employers were very difficult to survey and a number of them had gone out of business when they were contacted for a follow-up. Ms. Kinzel noted that in her 2004-2005

survey of small employers, the survey demonstrated that employers pursue all options available to avoid becoming part of the individual market.

Mr. Lind noted that the national market is experiencing the same results with regard to the percentage of employers who drop coverage. The best way for small employers to bargain for a better product is to look into all of the options available, and hopefully agents are assisting them. Mr. Teeling offered that for small employers the issue is not so much one of choice but of cost.

Commission members commented that many employers are unaware of section 125 plans and the use of health savings accounts (HSAs). There is a learning curve for employers to utilize HSAs and they can be complicated. Agents can help with HSAs and health reimbursement accounts (HRAs). There are tax advantages that employers are not utilizing, and one duty of an exchange could be to provide information to employers and help them through these processes. In response to an inquiry about dental coverage, Mr. Lind noted that 63 percent of employers overall offer this coverage, and 21 percent of the micro employers do so.

Mr. Lind concluded by noting that federal health care reform efforts will ultimately drive health care reform, but Iowa is unique in that the population works together and can operate as a petri dish for the nation. Iowans have a can-do attitude and the Commission is unique and can provide a basis for developing meaningful reform for Iowa's population.

IV. Workgroup Reports

Chairperson Carlyle suggested that as a format for reviewing and voting on the workgroup recommendations for inclusion in the commission report, each workgroup provide background and a review of recommendations, followed by discussion and voting by the Commission. Each of the workgroups submitted a progress report, which is posted on the Commission's Internet site and was used for discussion.

A. Coverage of Adults Workgroup

Overview. Chairperson Carlyle provided an overview of the deliberations of Workgroup 1. The workgroup held four meetings and determined that the existing model of IowaCare should be used as a basis for addressing the charge to provide options for coverage for uninsured adults. He stated that if federal health care reform results in expansion of the Medicaid program to additional populations, Iowa will be in a better position to transition adults from an IowaCare expansion program to the Medicaid program.

Expand IowaCare. He noted that for voting purposes, recommendation 1, to expand IowaCare, would only be comprised of language contained in paragraphs 1, 4, and 5 of recommendation 1 of the report, as the other paragraphs are merely descriptive in nature. The recommendation would, therefore, include expanding IowaCare to create a regional delivery model to provide all but a tertiary level of care as close as possible to an IowaCare member's home; to expand the IowaCare benefits to include a limited pharmacy benefit; and to include a requirement that IowaCare participating providers continue to provide a reasonable level of uncompensated care.

Chairperson Carlyle noted that the Department of Human Services (DHS) developed rough proposals and costs for expansion of IowaCare, some of which would require increased state

funding, but the workgroup determined that the General Assembly should be presented with all options and make a decision rather than the workgroup narrowing the options. Mr. Koeppl noted that information provided during the meetings suggested that the majority of those enrolled in IowaCare have chronic conditions and are a very sick population overall, so the idea of providing care closer to home is encouraging. Chairperson Carlyle added that community health centers are caring for this population already, so it is logical to build on a regional system.

Fund Increases in DHS Technological Capacities. With regard to recommendation 2, the workgroup supports financing expanded technological capacity for DHS to provide for electronic eligibility determinations and other approaches to improve enrollment and retention.

Federal Health Care Reform Opt-In. Recommendation 3 suggests that Iowa pursue federal health care reform early opt-in opportunities.

Diabetic Registry. Recommendation 4 is to support the development of a statewide diabetic registry that includes the provision of prescription drugs and tracking for those with diabetes.

B. Use/Creation of State Pool

Overview. Mr. Charlie Wishman, presenting for Ms. Nichols, introduced Mr. Stiles, Mr. Teeling, and Commissioner Voss to provide an overview of the deliberations of Workgroup 2. Mr. Stiles noted that the first meeting of the workgroup included testimony from representatives of various nonprofits and small employers regarding concerns and experiences in purchasing health insurance. The areas of concern identified were the inability of employers to change carriers to obtain access to affordable premiums, and the reality that nonprofits with small staffs are affected by even one catastrophic claim. Many small employers need more education about options because they are not even aware that options may be available. Some have tried pooling, but then were affected by the so-called "death spiral" when one of the few employees had a catastrophic illness causing premiums to rise and healthy employees to flee the pool.

Mr. Teeling described the second meeting, when the perspective of insurers was presented. The insurance industry representatives presented concerns relating to pooling and controlling health care costs. The primary barrier to successful pooling is the wellness of the group. Wellness initiatives were identified as the key to addressing cost and realizing more affordable insurance premiums.

Commissioner Voss described the third meeting, during which entities that have experience with pooling arrangements addressed the workgroup. Stability is important to a successful pool. If a pool is established, it must have parameters to ensure stability and certainty such as a minimum time for participation. The pooling concept requires further review.

Recommendations. The workgroup initially presented two recommendations to the Commission, but following discussion determined that recommendation 2 relating to new directions for the workgroup should be eliminated, as it is more the purview of the entire Commission.

New Groups for State Pool. Recommendation 1 was rewritten to reflect the intent of the workgroup that it is not yet ready to recommend pooling, but that any additional study of pooling should include protections to ensure stability. Senator Hatch noted that there is funding for the Commission which might be used if the workgroup is interested in modeling the pooling concept.

Commissioner Voss noted that a study by the Department of Administrative Services and Department of Management some years ago reviewed the possibility of adding nonprofits and small employers to the state pool, but various issues including how to address collective bargaining were presented. Commissioner Voss suggested that if this study can be located, it could be instructive for further review of the pooling concept.

Members discussed whether pooling or some other alternative might be more successful in reducing costs. They also discussed that the state pool is a hybrid of a self-funded plan and a reinsurance plan and whether the state pool is one large pool or a conglomerate of several small pools. Workgroup 2 instructed that their one recommendation be rewritten to reflect the idea that while pooling is a concept worthy of further exploration, it is not ready for implementation, and that any further exploration should include review of measures to ensure stability.

C. Administration of Health Care Reform in Iowa

Overview. Vice Chairperson Williams presented the report of Workgroup 3. He remarked that the charge of Workgroup 3 was twofold: to address seamlessness of the system and to review the structure of an exchange. Vice Chairperson Williams presented Workgroup 3 with the following directive in its deliberations: 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?

Workgroup 3 held three meetings discussing the fundamentals of an exchange and opportunities for creating a more seamless health care system for children, adults, and families. Workgroup 3 initially presented six recommendations and amended these to include a seventh.

Recommendations. Recommendation 1 suggests that Iowa move toward a more seamless system in helping Iowans move between public and private sectors of the system; recommendation 2 is to invest in technology to enhance the seamless system and it was suggested that this recommendation be combined with a similar recommendation regarding financing of technology from Workgroup 1; recommendation 3 suggests that information about safety net providers be more widely available; recommendation 4 suggests changes in law to increase opportunities for creditable coverage and this recommendation was amended to include the idea that any such changes must also address the concept of affordability so that those who are provided creditable coverage are also provided with affordable access; recommendation 5 suggests the aspects that should be addressed in developing an exchange; recommendation 6 addresses the need to include data on insurance plans and providers relating to cost and quality and data to consumers and funders on the cost of medical care; and recommendation 7 relates to establishing a task force to develop priorities in health care reform.

Discussion. With regard to the issue of affordability and creditable coverage, Senator Hatch suggested that it is not only the issue of cost, but who pays for it. Senator Hatch also suggested that the Commission is the entity that should prioritize health care reform issues and policies rather than appointing another task force. He noted that the General Assembly could amend the directives to the Commission to allow for this, but that the existing legislation is probably broad enough to provide for this.

The members discussed the description of an exchange as light, medium, or heavy, and Ms. Kinzel suggested that in the alternative they be referred to as a clearinghouse model, a market organizer model, and an active purchasing model.

The members discussed the need to include cost containment and quality data as part of the informational aspect of an exchange. Ms. Browne noted that consumers and insurers need access to information regarding the real cost of health care. It was suggested that information also be included to educate employers about section 125 plans and other options. Information should also be provided regarding the percentage of claims paid by insurers and what the consumers receive for their premiums, as well as complaints filed.

Members discussed the need for uniform quality standards and Chairperson Carlyle cautioned that quality standards are difficult to establish and must be risk-adjusted. The members suggested that addressing issues of transparency should not be contingent on the establishment of an exchange, but that such initiatives should move forward independently.

D. Approval of Reports

The members voted unanimously to accept the recommendations as amended during the discussion of the reports, with the exception of the recommendation to begin the process of designing an exchange. Mr. Teeling, Ms. Crookham-Johnson, and Ms. Browne voted in opposition to this recommendation.

Future Meetings. Ms. Kinzel will prepare a draft report for distribution to the Commission by December 22, 2009. The members will have until December 29, 2009, to respond to the report and the Commission will hold a meeting on January 6, 2010, to formally approve the report. Members who are not able to attend the meeting in person on January 6, 2010, may vote in advance.

E. 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=484

1. David Lind's PowerPoint Presentation.
2. Workgroup 1 Progress Report Draft from Chairperson David Carlyle.
3. Workgroup 2 Progress Report Draft from Chairperson Marcia Nichols.
4. Workgroup 3 Progress Report Draft from Chairperson Ted Williams.
5. Early Deliverables provided by Jennifer Vermeer.
6. Long Summary provided by Jennifer Vermeer.
7. Section-by-Section provided by Jennifer Vermeer.
8. Short Summary provided by Jennifer Vermeer.
9. Timeline provided by Jennifer Vermeer.

10. Children's Health Fact Sheets, provided by Health Coordinator Anne Kinzel.
11. Iowa Medicaid Fact Sheet, provided by Health Coordinator Anne Kinzel.

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