MINUTES

Legislative Health Care Coverage Commission

July 21, 2010

MEMBERS PRESENT:

Voting Public
Dr. David Carlyle, Chairperson
Mr. Ted Williams, Vice Chairperson
Ms. Betty Ahrens
Ms. Joan Jaimes (by phone)
Mr. Bruce Koeppl
Mr. Tim Stiles
Mr. Joe Teeling
Mr. Charlie Wishman
(designee of Ms. Marcia Nichols)

Nonvoting Legislative Members
Senator Jack Hatch
Representative Linda Upmeyer

Nonvoting Ex Officio Members
Mr. Tom Newton
Ms. Jennifer Vermeer
(designee of Mr. Charles Krogmeier)

MEETING IN BRIEF

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Organizational staffing provided by: Ann Ver Heul, Senior Legal Counsel, (515) 281-3837, and Patty Funaro, Senior Legal Counsel, (515) 281-3040

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

I. Procedural Business

Call to order and adjournment. The meeting was called to order at 10:07 a.m. in Room 103 of the State Capitol and was adjourned at 2:53 p.m.

II. Welcome, Overview, and Vision for 2010

Following introduction of the members, Chairperson Carlyle congratulated the Commission on the passage of Senate File 2356, which incorporated several of the Commission's recommendations, including the expansion of the IowaCare program and creation of a diabetic registry. He noted that with the 2009 Commission, there were many unknowns regarding the future of national health reform, but in 2010, with the passage of the federal Patient Protection and Affordable Care Act (PPACA), the Commission now has specific ideas about what national health reform includes and the goals of the Commission workgroups have been changed to help implement these reforms in a functional way.

Workgroup I, formerly Coverage of Adults, is now charged with IowaCare program expansion, Medicaid program expansion readiness, and the high-risk pool. IowaCare will transition to be part of the Medicaid program in 2014, and in the intervening years IowaCare will expand its provider network to federally qualified health centers and utilize the medical home model. These new elements will be implemented in October 2010. If the IowaCare medical home model is successful, it will then expand to the Medicaid program. Concurrently, a medical home model is being implemented as a demonstration project with private insurers. Workgroup I will also review options for Medicaid expansion, which will provide coverage up to 133 percent of the federal poverty level (FPL) beginning in 2014, and will review the option of co-ops as provided in the federal legislation. Workgroup I is also charged with monitoring the state high-risk pool.

Workgroup II, formerly Use/Creation of a state pool, is now charged with examining value-based health care. Workgroup III, formerly Administration of Health Care Reform in Iowa, is now charged with advising the Insurance Division regarding the state insurance information exchange and in making the federally required exchange, slated to begin in 2014, functional for Iowans. Newly created Workgroup IV will focus on prevention and wellness.

Chairperson Carlyle noted that legislative leaders have asked the Commission to complete its work by the end of January 2011, but may agree to its continuation if a compelling case to do so is made. Chairperson Carlyle suggested that the Commission have a mid-October to late-October conference call, and hold its two remaining meetings in mid-November and December.

III. Health Reform Update — State Opportunities and Challenges

Dr. JoAnn Lamphere, AARP Director, State Government Relations, Health and Long-term Care Issues, noted her work in Iowa nine years earlier with the Department of Public Health (DPH) holding focus groups to determine who the uninsured are in Iowa. Knowing who the uninsured are in Iowa is still relevant to making health reform work in the future. States have been the laboratories in addressing health care. Iowa and other states in the heartland have a tradition of civic engagement and commitment to social well-being, work to build collective expertise through bipartisan health policy engagement and experimentation, and have respected public health and

private insurance sector leadership. Iowa is in the forefront on addressing key health indicators including commitments to providing health care coverage for children and addressing mental health needs.

On the national front, support for health care reform in PPACA is improving with the majority of the favorable opinions being among Democrats. If polled as separate elements, large bipartisan majorities do favor specific elements of the law. There are challenges to the law in the form of constitutional challenges, state ballot initiatives, and proposed state legislation and nonbinding resolutions in a number of states. AARP is committed to educating the public through several avenues. (Fact sheets on health care reform prepared by the AARP Public Policy Institute are available at http://www.aarp.org/health/health-care-reform/info-04-2010/healthreformfs.html).

Dr. Lamphere reviewed the benefits of PPACA that affect insurance markets and coverage including small business tax credits; temporary high-risk pools; continuation of coverage for young adults; rescision prohibition; medical loss ratio requirements; restrictions related to pre-existing conditions, premium variations, and lifetime and annual caps; the individual coverage mandate to promote a culture of coverage; expansion of Medicaid to 133 percent of the FPL and changes in the computation of income; and the provision of subsidies for those with incomes between 133 and 400 percent of the FPL. Going forward, policymakers will have to determine a process and timeline to ensure that the Medicaid program interfaces with the private insurance market, including if current insurance laws are compatible with the federal law and its Medicaid program provisions.

With regard to the insurance market and exchanges, states have choices to make about how to create the exchange for their states. Elements to consider include governance, integration with the Medicaid program and subsidies, oversight and consumer protection, the information technology (IT) platform which would be available to the two million Iowans below 400 percent of the FPL and integrate access to Medicaid, purchase of insurance through the private market, assistance with receipt of subsidies, and the selection of plans to be included in the exchange. An exchange can be structured as weak or strong vis-a-vis the issues of governance; oversight of rates; benefit design and quality; usefulness, including seamlessness, outreach, and providing meaningful and manageable choices; sustainability by protecting against adverse selection and improving efficiency; and size with a larger exchange enabling quality improvements, cost cutting, and assuring stability and economies of scale. The state will need a business plan to coordinate policy and implementation among affected agencies.

There are several provisions in PPACA that provide strong incentives to improve home and community-based services, nursing home quality, and health care delivery and quality.

The law will take years to implement and challenges to states include the economy and its effect on state policymaking priorities; public anxiety about government spending, shortfalls, and program sustainability; health and insurance expertise leaving state service through retirement; the aging IT infrastructure; and the impact of lawsuits and other activities.

Members discussed the new high-risk pool under PPACA and the best way to maximize the effect on the uninsured in Iowa. Some ideas include tinkering with the subsidy mechanism, limiting the pool to only those with certain medical conditions, or asking insureds, who are by definition high

cost, to pay more. Another option is to enhance education and outreach regarding the various high-risk pools in the state.

Dr. Lamphere explained that adverse selection can be controlled by state regulation. If the state allows the plans included in the exchange to differ from those offered outside the exchange, healthier individuals could find coverage outside the exchange.

There are many grant and other funding opportunities under PPACA, but many of the rules and guidelines for these opportunities are not yet available. However, the state can determine and address state policy constraints or inconsistencies with PPACA and also determine what is most valuable to Iowa consumers. Outreach funding will be available to the states, and a new federal website was launched in early July 2010 to assist consumers. Dr. Lamphere discussed options and policy considerations in developing health insurance exchanges required by PPACA. There are examples of successful information exchanges, including the Iowa Senior Health Insurance Information Program (SHIIP).

IV. Legislator Statements

Representative Upmeyer noted that Iowa provides low-cost, high-quality health care as compared to other states. She said that Iowa has provided health care coverage for most of its children, already has a high-risk pool for those who cannot obtain health insurance elsewhere, and has the IowaCare program that provides coverage for adults using a common sense Midwestern approach. Representative Upmeyer listed six specific tasks that S.F. 389 requires the Commission to address as part of its work in developing a strategic plan, as well as a requirement that the Commission consult with health care coverage experts on a number of issues, and asked that the Commission report on where the work stands as to each of those items. Chairperson Carlyle said that the items will be assigned to the workgroups to address, and their findings will be included in the Commission's final report to the General Assembly.

Senator Hatch thanked the individuals at the University of Iowa Public Policy Center and University of Iowa Health Care who were responsible for hosting the Forkenbrock Series on Public Policy symposium on health care reform on July 20, 2010. He noted the event was the first such event held by a state to address implementation of federal health care reform. Senator Hatch noted that there was much discussion at the federal level during development of the federal legislation regarding state implementation and there was a realization that even though the law was passed at the national Capitol, implementation would take place in each state capitol. Federal officials have been surprised at the number of states that have elected to run their own high-risk pools. The role of the states is significant and will be challenging, especially in such a politically charged environment. Nonetheless, Senator Hatch encouraged the Commission to move forward to provide a forum for civic engagement and collective ideas regarding implementation.

Both Representative Upmeyer and Senator Hatch supported the continuation of the Commission beyond its final report at the end of January 2011. Senator Hatch encouraged Commission members as well as other interested parties to, as leaders, support continuation of the Commission. Representative Upmeyer noted that the Commission has been a source of nonpartisan debate on health care reform in determining what is best for Iowa. Chairperson

Carlyle applauded the legislative members of the Commission and the other members of the General Assembly for their support of the Commission and its work.

V. Patient Protection and Affordable Care Act Timeline and Update on Grants

Commission Coordinator Ms. Anne Kinzel presented a timeline of changes and requirements contained in PPACA beginning in 2010 and continuing up to 2018, with the major impacts of the law culminating in 2014. Ms. Kinzel included the major components of the federal legislation and potential impacts on Iowans, particularly the uninsured.

Chairperson Carlyle noted that legislative leaders have requested the assistance of the Commission in reviewing the document provided by Ms. Kinzel entitled "State Funding Opportunities — The Patient Protection and Affordable Care Act" and providing recommendations to leaders to be shared with the executive branch and Iowa's congressional delegation. Members discussed the need to make recommendations without micromanaging state agencies and considering capacity and resource issues. Members discussed the need to take advantage of early opportunities for funding, the need for state agencies to work together, and the need to support the role of consumers in the process.

VI. State Agency Updates

Department of Human Services (DHS). Ms. Jennifer Vermeer, Iowa Medicaid Director, discussed the activities of DHS in implementing PPACA, and specifically expansion of the Medicaid program. The department is working backward from the main implementation date of 2014 in developing its work plan. One of the biggest challenges is the Medicaid eligibility process, which must be reengineered. There are IT hurdles, and guidance is needed from the Centers for Medicare and Medicaid Services (CMS). CMS is sending out guidance regarding the most imminent activities. The department must also determine how the Medicaid program will interact with the health insurance exchange. There are resource challenges, so DHS must be strategic and choose what makes the most sense for Iowa. A national workgroup involving the National Governors' Association, the National Association of State Medicaid Directors, the American Public Human Services Association, and others is meeting biweekly and meetings have been held with representatives of the White House. Input is definitely being sought from the states in addressing implementation issues.

Ms. Vermeer noted that the current eligibility system is utilized for a number of assistance programs and requires a large amount of manual processing. The new Medicaid eligibility requirements will be a significant departure from the current requirements. DHS would like to integrate the Medicaid eligibility platform with the exchange and is working to complete a thorough analysis on which to base its request to the General Assembly for adequate resources. The federal government provides less of a match for the costs of eligibility systems (50 percent) compared with claims systems (90 percent), and even though Medicaid eligibility varies across the states, making it difficult to reduce costs by partnering with other states in developing and managing IT systems, with the need for integration of exchanges, there might be potential for this in the future.

Ms. Vermeer stated that it would be optimal to do all planning activities now and then request funding over a period of years leading up to full implementation in 2014. Full implementation cannot be accomplished with current staff and resources. From a policy standpoint, it would be best if all agencies involved in the exchange move together and have an understanding of how they want the exchange to work before the IT experts sketch out the final product. There might be solutions already available, and the insurance industry must be involved as well.

With regard to the Medicaid expansion and expansion of IowaCare, the department is working to incorporate the medical home concept into the IowaCare program and then will expand this to the Medicaid program if the demonstration is successful. Federal funding will be available for this. DHS is working on the medical home and health IT with DPH. Overall, the role of Medicaid is changing and the department is contemplating what needs to be done to advance this changed role by 2014.

As to grant opportunities, DHS is focusing on a state plan amendment in collaboration with DPH, relating to medical homes as a way to receive additional funding. The department does not have the capacity to take on all of the opportunities for grants. One example of an opportunity DHS will forego is crisis mental health grants, because Iowa does not have the necessary private institutions for mental disease to be eligible.

Agency representatives meet every two weeks to develop a strategic approach and ensure that opportunities are not missed. The departments will need assistance from the Commission and the General Assembly to make policy decisions. The task is large, but doable.

Department of Public Health. Mr. Tom Newton, Director of Public Health, distributed two documents relating to provisions of PPACA affecting DPH. He reviewed the federal funding opportunities that DPH has identified as priorities, to date, including: Maternal, Infant, and Early Childhood home visiting programs; personal responsibility education; establishment of a pregnancy assistance fund; nursing assistant and home health aide program; demonstration projects to address health professions workforce needs; prevention and wellness with a priority for obesity prevention and fitness; and public health infrastructure. DPH is also collaborating with Iowa Workforce Development, which is the lead agency, for an application for state health care workforce development grants. DPH also has capacity issues and is working to prioritize its activities. DPH is rethinking its role as a public health agency and whether certain services have long-term viability as all citizens become insured. DPH is having discussions with providers, local health departments, and others. The whole concept of care coordination could be a role for local public health departments. Rural areas of the state will still require different services than more urban areas. DPH can play a role in health IT and the number one priority is providing a sufficient workforce. There will always be a place for public health in areas of disease prevention, outreach, and other areas.

Insurance Division. Ms. Kinzel provided an update on behalf of the Insurance Division. The division is working on options for the state information exchange, cognizant of the fact that it will have to match up with the federal exchange. The division is also working on medical loss ratios and has already had a number of calls, about 12 per day, regarding the new high-risk pool. The division has been advising callers there is a limited number of slots and if they want to switch from the existing high-risk pool, they must go without coverage for six months before applying for the

new pool. One issue for the high-risk pool board in signing a contract with the federal government has been the board's liability if federal funding is insufficient to cover enrollees in the pool. The division is also working with agents and consumers to meet the new requirements for preventive care coverage in health insurance plans. The new high-risk pool has not yet begun taking applications. The top priority for the division at this point is determining medical loss ratios, which are required to be used by health plans beginning in 2011. It was noted that Commissioner of Insurance Susan Voss is president-elect of the National Association of Insurance Commissioners (NAIC) and that NAIC is making recommendations to the United States Department of Health and Human Services regarding medical loss ratios.

VII. Demonstration Project on Medical Homes

Ms. Beth Jones, DPH, stated that the Medical Home Advisory Council is working on a multi-payor initiative pilot project to meet the requirement that Medicaid enrollees receive health care in the context of a medical home. Ms. Jones stated that Iowa is designing a plan with Wellmark and Medicaid that meets specific federal guidelines for participation in the federal initiative. She anticipates that the medical home project will roll out by mid-2011.

VIII. Workgroup Updates

A. Workgroup I — IowaCare Expansion, Medicaid Expansion Readiness, and High-Risk Pool

Workgroup Chairperson Carlyle indicated that Ms. Vermeer had already presented details about the IowaCare expansion and that while it is expanding service availability, IowaCare is still a limited program. Chairperson Carlyle said that the workgroup has met once and the workgroup's plans include trying to maximize participation in the state's current high-risk pool, discussion of the use of co-ops to increase health care coverage opportunities, and recommendations concerning the creation of the diabetic registry.

B. Workgroup II — Value-based Health Care

Workgroup Chairperson Marcia Nichols designated Mr. Charlie Wishman to report on the activities of the workgroup. Mr. Wishman said that the workgroup has met twice. Dr. Michael Kitchell, on behalf of the Iowa Medical Society, and Ms. Shannon Strickler, on behalf of the Iowa Hospital Association, presented information to the workgroup about value-based health care which has the goals of achieving both higher quality and lower costs for health care. At its next meeting, Workgroup II will have presentations from the Health Buyers Alliance and the insurance industry. Commission members suggested that Workgroup II might request input from Dr. Tom Evans, President and CEO of the Iowa Healthcare Collaborative, and review ways to address Medicare fraud.

C. Workgroup III — Insurance Information Exchange

Workgroup Chairperson Ted Williams stated that the workgroup has held two meetings and they are in the process of educating themselves on the requirements for the state health information

exchange created in S.F. 2356. The workgroup has met with representatives of the state agencies involved, including the Medicaid Enterprise, DPH, and the Insurance Division. The Insurance Division is taking the lead on planning for the new exchange but is waiting for federal guidance on how the insurance exchanges required in 2014 by PPACA will be implemented so that work done on the state information exchange is not inconsistent and can serve as a foundation for creation of the more comprehensive exchange. Commission Chairperson Carlyle asked that Workgroup III present recommendations for a plan of operation for the insurance information exchange at the next meeting of the Commission.

D. Workgroup IV — Wellness

Workgroup Chairperson Joe Teeling stated that this newly created workgroup will begin meeting in August and intends to take testimony from 20-30 organizations from both within and outside the state to discuss cutting edge cost-control efforts, including how to design incentives to change behavior for clients that will bend the curve on health care costs. Chairperson Teeling indicated that the workgroup would like to present information about wellness and prevention initiatives at a Commission meeting.

IX. Commission Discussion

Chairperson Carlyle suggested that the Commission be presented with information about rural health care at its November meeting, and Representative Upmeyer suggested contacting the Rural Health and Primary Care Advisory Committee in the DPH.

Chairperson Carlyle noted again that leaders submitted a letter requesting recommendations from the Commission regarding federal grant and other funding opportunities. Members discussed the need to provide input while not micromanaging agencies or overwhelming agencies beyond their resources or capacities. Members expressed concern about opportunities that have already been missed including an opportunity relating to funding for a health insurance premium review for which the deadline has passed.

After discussion, the Commission adopted a motion encouraging the directors of state agencies, in particular the Insurance Division, DHS, and DPH, to pursue federal grants available to such state agencies under PPACA concerning health care reform, including those grants specifically referred to by Ms. Vermeer and Director Newton in their presentations to the Commission, and to periodically provide a list to the Commission of the grants they are planning to apply for and the status of grant applications. Commissioner Teeling voted “no” on the motion.

X. Upcoming Meetings

Chairperson Carlyle indicated that the next meeting of the Commission will be held in November, with a possible conference call in October.

XI. 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. Health Reform Implementation — State Opportunities and Challenges — JoAnn Lamphere — Revised
2. Health Reform/State Funding Opportunities — from Legislative Leadership
3. Iowa Department of Public Health Provisions Table 7-9-10
4. Iowa Department of Public Health Work Plan 7-16-10
5. Federal Patient Protection and Affordable Care Act Timeline
6. State Funding Opportunities by Anne Kinzel

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