January 19, 2010

Honorable Michael Gronstal
Senate Majority Leader
State Capitol
Des Moines IA 50319

Honorable Pat Murphy
Speaker of the House
State Capitol
Des Moines IA 50319

Honorable Chester Culver
Governor, State of Iowa
State Capitol
Des Moines IA 50319

As Chair of the Legislative Health Care Coverage Commission, I am please to submit the Commission's 2009 Progress Report, including its 10 recommendations. The report, prepared pursuant to Senate File 389, was approved by a unanimous vote of the Commissioners on January 6, 2010.

As you will see in the report, the Commission and its three workgroups met on numerous occasions between September and December 2009, while focusing efforts on the development of new opportunities for increasing access to health care among currently uninsured adult Iowans.

The report is also available on the Commission's website at www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=484

Sincerely,

David A. Carlyle

David Carlyle, MD
Commission Chair

PROGRESS REPORT

Legislative Health Care Coverage Commission

January 2010

MEMBERS

Voting Public

Dr. David Carlyle, Chairperson
Mr. Ted Williams, Vice Chairperson
Mr. Mike Abbott
Ms. Betty Ahrens
Ms. Jennifer Browne
Ms. Diane Crookham-Johnson
Ms. Joan Jaimes
Mr. Bruce Koeppl
Ms. Marcia Nichols
Mr. Tim Stiles
Mr. Joe Teeling

Nonvoting Legislative Members

Senator Jack Hatch
Senator David Johnson
Representative Mark Smith
Representative Linda Upmeyer

Nonvoting Ex Officio Members

Mr. Charles Krogmeier
Mr. Tom Newton
Ms. Susan Voss

Staff Contacts:

Report prepared by: Anne Kinzel, Commission Coordinator, (515) 554-6021

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Ann Ver Heul, Senior Legal Counsel, (515) 281-3837
Patty Funaro, Senior Legal Counsel, (515) 281-3040

Contents:

AUTHORIZATION AND APPOINTMENT

The Commission is required, by 2009 Iowa Acts, Ch. 118, §1 (S.F. 389, §1), to develop an Iowa health care reform strategic plan, addressing various aspects listed in the legislation. The Commission is created under the authority of the Legislative Council, with administrative support to be provided by the Legislative Services Agency (LSA). The Legislative Council is required to appoint a chairperson and vice chairperson from the voting membership. An appropriation of $200,000 for costs associated with the Commission, including any per diem or other expenses associated with meetings, is made to LSA in 2009 Iowa Acts, Ch. 183, §65 (H.F. 820, §65), as amended by 2009 Iowa Acts, Ch. 179, §160, (S.F. 478, §160). The Commission is required to complete its deliberations by July 1, 2011, provide quarterly reports, and provide annual progress reports on January 1, 2010, and 2011.

I. Introduction

A. Overview

The Legislative Health Care Coverage Commission (Commission) was created by 2009 Iowa Acts, Chapter 118, § 1 (S.F. 389) to prepare an Iowa health care reform strategic plan which includes, but is not limited to, a review and analysis of options for increased health care coverage of Iowa's children, adults, and families, with an emphasis on increased coverage for adults (Attachment A, Legislation). The Commission has also been directed to develop prioritized recommendations for increasing coverage. A full description of the Commission's charge is set forth in Section II below.

The Commission operates under the authority of the Legislative Council and has a defined existence set by statute, with a dissolution date of December 31, 2011. The Commission is required to conclude its deliberations by July 1, 2011, and to submit a final report to the General Assembly by October 1, 2011.

B. 2010 Progress Report

The Commission is required to submit a progress report to the General Assembly by January 1, 2010, summarizing the Commission's activities from September through December 2009. The progress report must provide prioritized recommendations for subsidized and unsubsidized health care coverage programs which offer public and private health care coverage for adults. The coverage must provide both an adequate benefits package and be affordable.[1]

The following sections of this progress report contain additional background information regarding the Commission's operations between September and December 2009, and the Commission's 11 initial (2009) recommendations. All 11 recommendations were approved by a majority of the Commission. The process for developing and approving recommendations is further described in Part IV, below.

II. Commission Charge

The Commission is charged with developing an Iowa health care reform strategic plan which includes, but is not limited to, a review and analysis of, and recommendations and prioritization of recommendations for, the following:

- Options for the coordination of a children's health care network in the state that provides health care coverage to all children without such coverage; utilizes, modifies, and enhances existing public programs; maximizes the ability of the state to obtain federal funding and reimbursement for such programs; and provides access to private, affordable health care coverage for children who are not otherwise eligible for health care coverage through public programs.
- Options for children, adults, and families to transition seamlessly among public and private health care coverage options.

[1] The Commission is also required to provide an annual report to the General Assembly by January 1, 2011, summarizing the Commission's activities during 2010, including but not limited to information about health care coverage for adults that was available for purchase by the public by July 1, 2010, including enrollment information, and including further recommendations and prioritization of those recommendations.

- Options for subsidized and unsubsidized health care coverage programs which offer public and private, adequate and affordable health care coverage including but not limited to options to purchase coverage with varying levels of benefits including basic or catastrophic benefits, an intermediate level of benefits, and comprehensive benefits coverage. The Commission shall also consider options and make recommendations for providing an array of benefits that may include physical, mental, and dental health care coverage. Affordable health care coverage options for purchase by adults and families shall be developed with the goal of including options for which the contribution requirement for all cost-sharing expenses is no more than six and one-half percent of family income.
- Options to offer a program to provide coverage under a state health or medical group insurance plan to nonstate public employees, including employees of counties, cities, schools, area education agencies, and community colleges, and employees of nonprofit employers and small employers and to pool such employees with the state plan.
- The ramifications of requiring each employer in the state with more than 10 employees to adopt and maintain a cafeteria plan that satisfies § 125 of the Internal Revenue Code of 1986.
- Options for development of a long-term strategy to provide access to affordable health care coverage to the uninsured in Iowa, particularly adults, and development of a structure to implement that strategy including consideration of whether to utilize an existing government agency or a newly created entity.

As part of developing the strategic plan, the Commission shall collaborate with health care coverage experts to do, including but not limited to, the following:

- Design solutions to issues relating to guaranteed issuance of insurance, preexisting condition exclusions, portability, and allowable pooling and rating classifications.
- Formulate principles that ensure fair and appropriate practices relating to issues involving individual health care policies such as recision and preexisting condition clauses, and that provide for a binding third-party review process to resolve disputes related to such issues.
- Design affordable, portable health care coverage options for low-income children, adults, and families.
- Design a proposed premium schedule for health care coverage options which includes the development of rating factors that are consistent with market conditions.
- Design protocols to limit the transfer from employer-sponsored or other private health care coverage to state-developed health care coverage plans.

III. Commission Membership

The legislation directed that the Commission membership be made up of 11 voting members and seven ex officio, nonvoting members. The 11 voting members appointed by the Legislative Council represent large and small employers, Iowa insurers, health underwriters, health care providers, labor, nonprofit entities, independent insurance agents, and consumers. The three

consumer members represent respectively the pre-Medicare population, middle-income adults and families, and low-income adults and families.

The ex officio membership is made up of the Director of Human Services, the Director of Public Health, and the Commissioner of Insurance, or their designees, and four legislators.

The Commission chairperson and vice chairperson, who were appointed by the Legislative Council, are Dr. David Carlyle, a physician, and Mr. Ted Williams, a small business owner (Attachment B, Commission Membership).

Voting members were allowed to name an alternate who was accorded full privileges in the absence of their principal.

IV. Commission Coordinator

The Legislative Council was authorized to employ or contract with a person to assist the Commission in developing the strategic plan by coordinating Commission activities; gathering information relating to health reform; serving as a liaison between stakeholders, other levels of government, and the Commission; and writing the Commission's progress reports and Final Report (Attachment C, Consultant Job Description). On October 1, 2009, Ms. Anne Kinzel was engaged to serve as Commission Coordinator.[2]

The Legislative Services Agency provides administrative support to the Commission and the Coordinator (Attachment D, Legislative Staff).[3]

V. Commission Meetings and Workgroups

The full Commission met on three occasions in the fall of 2009, with a large majority of the members attending each meeting. Commission meetings took place at the State Capitol building and were open to the public. In addition, a call-in telephone number was provided so that any member could attend a meeting by telephone. A tentative meeting agenda for each meeting was posted on the Commission's website <www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=484> prior to any Commission meeting.

The Commission also established three workgroups to address specific issues as is more fully described in Section B, below.

A. Commission Meetings and Focus

Each Commission meeting included a brief report by the legislative members on the status of federal health care reform. Workgroup progress reports were made at the October and December meetings. The following is a brief summary of the three Commission meetings. A full summary of each meeting is provided on the Commission's Workgroup websites which may be accessed from the Commission's website.

[2] See *Anne Kinzel Bio Statement and Resume* available at: <www.legis.state.ia.us/lsadocs/IntComHand/2010/IHAMV005.PDF>.
[3] The Legislative Services Agency prepared a *Background Memorandum on Recent Legislative Health Care Coverage Efforts in Iowa,* available at: <http://www.legis.state.ia.us/lsadocs/IntComDoc/2010/IDAMV000.PDF> that helps put this Commission's work in the larger context of Iowa's ongoing efforts to expand access to health care.

September 9, 2009

Commissioners reviewed and discussed the Commission's legislative charge, priorities, expectations, operating rules and its division into three workgroups. The Commission unanimously adopted rules at its first meeting on September 9, 2009 (Attachment E, Commission Rules). Chairperson Carlyle moderated a panel discussion — Current Status of Health Care Reform Efforts in Iowa. The panelists were Ms. Susan Voss, Iowa Insurance Commissioner; Ms. Julie McMahon and Dr. Kathy Schneider, Iowa Department of Public Health; and Ms. Jennifer Vermeer, Iowa Department of Human Services. Presentations were made by Ms. Devin Boerm, who discussed her situation with health insurance and illness, and Dr. Sara Imhof, who gave an update on the work of the Concord Coalition.[4] The Department of Public Health made available a presentation document: Health Reform in Iowa: Iowa Department of Public Health's Role.[5]

October 20, 2009

Representative Sharon Anglin Treat of the Maine Legislature gave a presentation on Maine's efforts at state level health reform, entitled Health Reform Efforts - Dirigo - Lessons Learned from Maine.[6] Each workgroup also met separately to go over its progress to date.

December 2, 2009

The three workgroups presented their recommendations to the full Commission for approval. Each recommendation was deliberated over in detail, and voted upon by the commissioners. The process is described in detail in Section VI, below. In addition, Mr. David Lind of David P. Lind & Associates, LC, a Des Moines-based independent employee benefits consulting firm, presented the results of the firm's 2009 Iowa Benefits Study© (Attachment F, 2009 Iowa Employer Benefits Study© — 11th Annual Study).

B. Commission Workgroups

At the direction of Commission Chairperson Carlyle, the Commission was divided into three workgroups. Each workgroup was assigned a specific charge and directed to hold as many meetings as were necessary to prepare workgroup recommendations for presentation to the full Commission on December 2, 2009.

The workgroups held numerous meetings at the State Capitol building and at various locations in the downtown Des Moines area. A tentative agenda for each meeting was posted on the Commission's website and, as with full Commission meetings, a call-in telephone number was provided so that any members could attend a meeting by telephone.

On several occasions, the workgroups invited experts to present information to assist the workgroup members in preparing recommendations. A description of each workgroup's activities is presented in the progress reports provided by each workgroup (Attachments G, H, and I).

[4] See Devin Boerm Testimony available at <www.legis.state.ia.us/lsadocs/IntComHand/2010/IHAMV011.PDF>. The document *Meetings on Value in HealthCare* available at <www.legis.state.ia.us/lsadocs/IntComHand/2010/IHAMV000.PDF>.
[5] See *Health Reform in Iowa: Iowa Department of Public Health's Role* available at: <www.legis.state.ia.us/lsadocs/IntComHand/2010/IHAMV006.PDF>.
[6] See also *Maine State Representative Sharon Treat's Biography* available at <www.legis.state.ia.us/lsadocs/IntComHand/2010/IHAMV026.PDF>, *National Health Reform Lessons from Maine,* Garrett Martin and Douglas Rook available at: <www.legis.state.ia.us/lsadocs/IntComHand/2010/IHAMV029.PDF>, and *Choices, Quality Affordable Health Care: A Work in Progress, A Window of Opportunity–Maine Center for Economic Policy* available at: <www.legis.state.ia.us/lsadocs/IntComHand/2010/IHAMV027.PDF>.

Additional information regarding workgroup activities is available at the workgroup websites which can be accessed at <www.legis.state.ia.us/Current/Interim/>).

The following presents brief information on each workgroup, including membership and charge.

1. **Workgroup 1 — Coverage of Adults**

    - Dr. David Carlyle (Chairperson)
    - Betty Ahrens
    - Diane Crookham-Johnson
    - Bruce Koeppel
    - Jennifer Vermeer (Department of Human Services designee)

    Workgroup 1 Charge:

    Workgroup 1 is tasked to review, analyze, recommend, and prioritize options to offer health coverage to uninsured and underinsured adults in the state by doing the following, including but not limited to:

    a. Presenting options for subsidized and unsubsidized health care coverage programs which offer public and private, adequate and affordable health care coverage, including but not limited to options to purchase coverage with varying levels of benefits including basic or catastrophic benefits, an intermediate level of benefits, and comprehensive benefits coverage.

    (1) Including options for providing an array of benefits that may include physical, mental, and dental health care coverage.

    (2) Including development of health care coverage options for purchase by adults and families with the goal of including options for which the contribution requirement for all cost-sharing expenses is no more than 6.5 percent of family income.

    b. Analyzing the ramifications of requiring each employer in the state with more than 10 employees to adopt and maintain a cafeteria plan that satisfies §125 of the Internal Revenue Code of 1986.

2. **Workgroup 2 — Use/Creation of State Pool**

    - Marcia Nichols (Chairperson)
    - Tim Stiles
    - Joe Teeling
    - Susan Voss

    Workgroup 2 Charge:

Workgroup 2 is tasked to review, analyze, recommend, and prioritize options to offer a program to provide coverage under a state health or medical group insurance plan to nonstate public employees of counties, cities, schools, area education agencies, and community colleges, and employees of nonprofit employers and small employers and to pool such employees with the state plan.

3. Workgroup 3 — Administration of Health Care Reform in Iowa

- Ted Williams (Chairperson)
- Mike Abbott
- Jennifer Browne
- Joan Jaimes
- Lynh Patterson (Department of Public Health Designee)

Workgroup 3 Charge:

Workgroup 3 is tasked to review, analyze, recommend, and prioritize options related to the administration of health care reform in Iowa and creation of an affordable, accessible, seamless health care coverage system for all Iowans, by doing, including but not limited to the following:

a. Presenting options for the coordination of a children's health care network in the state that provides health care coverage to all children without such coverage; utilizes, modifies, and enhances existing public programs; maximizes the ability of the state to obtain federal funding and reimbursement for such programs; and provides access to private, affordable health care coverage for children who are not otherwise eligible for health care coverage through public programs.

b. Presenting options for children, adults, and families to transition seamlessly among public and private health care coverage options.

c. Presenting options to develop a long-term strategy to provide access to affordable health care coverage to the uninsured in Iowa, particularly adults, and development of a structure to implement that strategy including consideration of whether to utilize an existing government agency or a newly covered entity.

VI. Commission Recommendations

This part of the progress report provides the Commission's recommendations to the General Assembly. Initially, workgroups developed their own set of recommendations. At the December 2, 2009, Commission meeting, each workgroup presented a progress report to the full Commission.

The reports contained workgroup recommendations for the Commission to either accept as written, modify, or decline to present to the General Assembly.

The commissioners voted on each workgroup's recommendations. Each vote was preceded by a discussion with workgroup members regarding the substance of each recommendation. Of the following 11 recommendations adopted by the Commission, all but Recommendation 5 were unanimously adopted by the Commission.[7]

Recommendation 1: Expand the IowaCare Program.

- Expand IowaCare to create a regional delivery model that will provide access to primary care and hospital care in the least geographically burdensome manner, which is defined as providing all but tertiary level care as close as possible to an IowaCare member's home.
- As part of an IowaCare expansion, the IowaCare benefits package should be amended to include a limited pharmacy benefit.
- An IowaCare regional delivery model should include provisions that will require IowaCare participating providers to continue to provide a reasonable level of uncompensated care.

Recommendation 2: Fund increases in DHS technological capacities.[8]

- Expand investments in technology. Invest in the technology necessary to power a more seamless system for Iowans moving from public health care to private health care coverage and for Iowans moving between public health insurance programs.
- Seek new funding sources. Iowa needs to continue to aggressively seek opportunities to leverage federal funds available for Department of Human Services technology enhancements.
- Deploy adequate staffing levels. State government needs to determine if it has adequate staffing levels to maintain a seamless system, and to the extent possible, add staff where necessary to promote seamlessness.

Recommendation 3: Iowa should pursue early opt-in opportunities presented by federal health care reform.

- Capitalize on Iowa's leadership. Iowa has a strong history of taking on a leadership role in health care access reform. If the federal government provides useful incentives for early adoption of measures that can increase access to affordable health care, the Commission recommends that Iowa move aggressively in pursuing these opportunities before 2014.

Recommendation 4: Iowa should develop a statewide diabetic registry.

- Improve diabetic care. To improve the care of diabetic patients and begin the process leading to upcoming Medicaid expansion, the state should set up a diabetic registry with the assistance of Iowa's Community Health Centers and free medical clinics, which in exchange

[7] Commissioners Browne, Crookham-Johnson, and Teeling voted "no" on Recommendations 9 and 10.
[8] Both Workgroup1 and Workgroup 3 sent recommendations to the full Commission regarding the need to increase DHS technological capacities. The recommendations were merged into one by the overall Commission during the December 2, 2009, Commission meeting.

for data and lab tests will provide a basic combination of medications, including anti-hypertensives, cholesterol-lowering agents, and diabetic medications.

Recommendation 5: Opening of the state pool is a concept worthy of further exploration, but not a process ready to be used. Prior to opening the state employee pool to new groups, further exploration is needed, including development of measures which will protect the stability of the state employee pool from both a cost and benefits perspective.

- Commitment term. Exit from pools, either from the state pool, if it is opened at some future date, or from other pools in Iowa, needs to be restricted by requiring that groups commit to a pool for a fixed number of years prior to being allowed to withdraw. Further research needs to be done to determine what the proper commitment (in years) should be before exit is allowed.

Recommendation 6: Iowa needs to develop a more seamless system for Iowans moving from public health care to private health care coverage, and moving from one public health insurance program to another.

- Implement past recommendations. The Commission should work with the Department of Human Services to examine current and past recommendations to improve transitions between the Medicaid and hawk-i programs and to prioritize those recommendations which have not yet been put into effect.
- Create a common portal for public program eligibility determinations. To the extent legally possible, the state should begin using common definitions of income for determination of public program eligibility.

Recommendation 7: The Iowa Insurance Division and the Commissioner of Insurance should pursue all statutory options to improve seamlessness through increasing opportunities for "creditable coverage" in Iowa.

- Provide financial support. The Commission recognizes that Iowans who have been denied access to coverage can obtain insurance through the Iowa Comprehensive Health Insurance Association. However, pending federal health care reform, the affordability of this and other coverage is limited and funding must be made available to help reduce premiums to the extent feasible given the state's budgetary situation.

Recommendation 8: Information should be readily available to Iowans that provides details about the health care services provided by the safety net providers, specifically all of the following:

- The population served by safety net providers.
- Where safety net providers are located in Iowa.
- What services safety net providers offer.

Recommendation 9: Iowa should begin the process of designing an Iowa exchange.

The following issues need to be examined in designing an Iowa exchange:

- What functions should an Iowa exchange include? If the exchange includes involvement in insurance benefit design, the following benefit components should be considered for inclusion:
    - A medical home model
    - A focus on prevention
    - Provisions for chronic care management

Even in the absence of the creation of an Iowa exchange, the above functions are important to assure adequate insurance benefit design and should be considered by Workgroups 1 and 2 as they pursue their respective charges.

- What is the optimum exchange model for Iowa? The Commission believes that federal health care reform will, in all likelihood, determine the form that exchanges will take. However, to the extent Iowa has the opportunity to do so, the state should determine what model of exchange will produce the best opportunities for promoting affordable coverage given the state's demography and economy.
- Who should be included in an Iowa exchange? Should an Iowa exchange include the individual and small group markets and public plans? The Commission recommends that an Iowa exchange include public and private sector participation.
- Should participation in an Iowa exchange be voluntary? The Commission believes that unless Iowa has an individual coverage mandate, guaranteed issue, and adequate subsidies for purchase of coverage for persons not eligible for public coverage, an Iowa exchange should only serve as an information clearinghouse with a focus on promoting seamless coverage transitions (public to private and vice versa and between public programs). Additionally, the clearinghouse model exchange should provide information for the general public on health care quality and cost. If Iowa moves to an individual mandate, guaranteed issue, and coverage subsidies, there will be a need to revisit Iowa exchange design.
- Who should operate an Iowa exchange? The Commission recommends that state government should facilitate the creation of the exchange and assume operational oversight responsibility.

Recommendation 10: An Iowa exchange will need to provide quality data on providers and plans, and data to consumers and funders on the cost of medical care.

- Expand transparency. It is currently difficult to obtain data on provider pricing and Iowa should consider expanding opportunities to promote greater transparency. Iowa will need to look at creating and/or encouraging the development and usage of common definitions for quality of care and health care prices.

Recommendation 11: The Commission should identify and prioritize those issues and public health concerns that when addressed could make the greatest impact on the health of Iowans and thereby also improve the overall level of cost of care.

VII. Next Steps

The Commission and its workgroups will continue to meet throughout 2010 and beyond. The focus will be on fulfilling the Commission's statutory charge and monitoring progress on the Commission's 11 recommendations. The Commission will monitor anticipated federal health care reform legislation with a goal of developing a complete understanding of how anticipated federal reforms will impact the Commission's charge and recommendations, and potentially drive opportunities to increase coverage for lower income adults.

VIII. Attachments

A. Legislation.

B. Commission Membership.

C. Coordinator Job Description.

D. Legislative Staff.

E. Commission Rules.

F. 2009 Iowa Employer Benefits Study.

G. Workgroup I – Coverage of Adults.
Progress Report.

H. Workgroup II – Use/Creation of State Pool Progress Report.

I. Workgroup III – Administration of Health Care Reform in Iowa Progress Report.

J. Materials Filed With the Commission.

3769IC

Senate File 389 - Enrolled

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SENATE FILE 389

AN ACT

RELATING TO HEALTH CARE, HEALTH CARE PROVIDERS, AND HEALTH CARE COVERAGE, PROVIDING RETROACTIVE AND OTHER EFFECTIVE DATES AND PROVIDING REPEALS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

LEGISLATIVE HEALTH CARE COVERAGE COMMISSION

Section 1. LEGISLATIVE HEALTH CARE COVERAGE COMMISSION.

1. A legislative health care coverage commission is created under the authority of the legislative council.

a. The commission shall include the following persons who are ex officio, nonvoting members of the commission:

(1) The commissioner of insurance, or a designee.

(2) The director of human services, or a designee.

(3) The director of public health, or a designee.

(4) Four members of the general assembly, one appointed by the speaker of the house of representatives, one appointed by the minority leader of the house of representatives, one appointed by the majority leader of the senate, and one appointed by the minority leader of the senate.

b. The commission shall include the following persons who are voting members of the commission and who are appointed by the legislative council:

(1) A person who represents large employers.

(2) A person who represents Iowa insurers.

(3) A person who represents health underwriters.

(4) A health care provider.

(5) A person who represents labor.

(6) A consumer who represents the pre=Medicare population.

(7) A consumer who represents middle=income adults and families.

(8) A consumer who represents low=income adults and families.

(9) A person who represents small businesses.

(10) A person who represents nonprofit entities.

(11) A person who represents independent insurance agents.

2. The legislative council may employ or contract with a person or persons to assist the commission in carrying out its duties. The person or persons employed or contracted with to assist the commission shall gather and coordinate information for the use of the commission in its deliberations concerning health reform initiatives and activities related to the medical home system advisory council, the electronic health information advisory council and executive committee, the prevention and chronic care management advisory council, the direct care worker task force, the health and long=term care access technical advisory committee, the clinicians advisory panel, the long=term living initiatives of the department of elder affairs, medical assistance and hawk=i program

expansions and initiatives, prevention and wellness initiatives including but not limited to those administered through the Iowa healthy communities initiative pursuant to section 135.27 and through the governor's council on physical fitness and nutrition, health care transparency activities, and other health care reform=related advisory bodies and activities that provide direction and promote collaborative efforts among health care providers involved in the initiatives and activities. The legislative services agency shall provide administrative support to the commission.

3. The legislative council shall appoint one voting member as chairperson and one as vice chairperson. Legislative members of the commission are eligible for per diem and reimbursement of actual expenses as provided in section 2.10. The consumers appointed to the commission are entitled to receive a per diem as specified in section 7E.6 for each day spent in performance of duties as a member, and shall be reimbursed for all actual and necessary expenses incurred in the performance of duties as a member of the commission.

4. The commission shall develop an Iowa health care reform strategic plan which includes but is not limited to a review and analysis of, and recommendations and prioritization of recommendations for, the following:

a. Options for the coordination of a children's health care network in the state that provides health care coverage to all children without such coverage; utilizes, modifies, and enhances existing public programs; maximizes the ability of the state to obtain federal funding and reimbursement for such programs; and provides access to private, affordable health care coverage for children who are not otherwise eligible for health care coverage through public programs.

b. Options for children, adults, and families to transition seamlessly among public and private health care coverage options.

c. Options for subsidized and unsubsidized health care coverage programs which offer public and private, adequate and affordable health care coverage including but not limited to options to purchase coverage with varying levels of benefits including basic or catastrophic benefits, an intermediate level of benefits, and comprehensive benefits coverage. The commission shall also consider options and make recommendations for providing an array of benefits that may include physical, mental, and dental health care coverage. Affordable health care coverage options for purchase by adults and families shall be developed with the goal of including options for which the contribution requirement for all cost=sharing expenses is no more than six and one=half percent of family income.

d. Options to offer a program to provide coverage under a state health or medical group insurance plan to nonstate public employees, including employees of counties, cities, schools, area education agencies, and community colleges, and employees of nonprofit employers and small employers and to pool such employees with the state plan.

e. The ramifications of requiring each employer in the state with more than ten employees to adopt and maintain a cafeteria plan that satisfies section 125 of the Internal Revenue Code of 1986.

f. Options for development of a long=term strategy to provide access to affordable health care coverage to the

uninsured in Iowa, particularly adults, and development of a structure to implement that strategy including consideration of whether to utilize an existing government agency or a newly created entity.

5. As part of developing the strategic plan, the commission shall collaborate with health care coverage experts to do including but not limited to the following:

a. Design solutions to issues relating to guaranteed issuance of insurance, preexisting condition exclusions, portability, and allowable pooling and rating classifications.

b. Formulate principles that ensure fair and appropriate practices relating to issues involving individual health care policies such as recision and preexisting condition clauses, and that provide for a binding third=party review process to resolve disputes related to such issues.

c. Design affordable, portable health care coverage options for low=income children, adults, and families.

d. Design a proposed premium schedule for health care coverage options which includes the development of rating factors that are consistent with market conditions.

e. Design protocols to limit the transfer from employer=sponsored or other private health care coverage to state=developed health care coverage plans.

6. The commission may request from any state agency or official information and assistance as needed to perform its duties pursuant to this section. A state agency or official shall furnish the information or assistance requested within the authority and resources of the state agency or official. This subsection does not allow the examination or copying of any public record required by law to be kept confidential.

7. The commission shall provide progress reports to the legislative council every quarter summarizing the commission's activities.

8. The commission shall provide a progress report to the general assembly by January 1, 2010, summarizing the commission's activities thus far, that includes but is not limited to recommendations and prioritization of recommendations for subsidized and unsubsidized health care coverage programs which offer public and private and adequate and affordable health care coverage for adults. The commission shall collaborate with health care coverage experts to ensure that health care coverage for adults that is consistent with the commission's recommendations and priorities is available for purchase by the public by July 1, 2010.

9. The commission shall provide a report to the general assembly by January 1, 2011, summarizing the commission's activities since the previous annual report provided on January 1, 2010, including but not limited to information about health care coverage for adults, including enrollment information, that was available for purchase by the public by July 1, 2010, consistent with the commission's recommendations and priorities, and including further recommendations and prioritization of those recommendations.

10. The commission shall conclude its deliberations by July 1, 2011, and shall submit a final report to the general assembly by October 1, 2011, summarizing the commission's activities particularly pertaining to the availability of health care coverage programs for adults, analyzing issues studied, and setting forth options, recommendations, and

priorities for an Iowa health care reform strategic plan that will ensure that all Iowans have access to health care coverage which meets minimum standards of quality and affordability. The commission may include any other information the commission deems relevant and necessary.

11. This section is repealed on December 31, 2011.

House File 820, section 65, subsection 3:

3. There is appropriated from the human services reinvestment fund for the fiscal year beginning July 1, 2009, and ending June 30, 2010, the following amount to be used for the following designated purpose:

For the legislative services agency to be used for costs associated with the legislative health care coverage commission created in 2009 Iowa Acts, Senate File 389, if enacted, or a similar legislative commission:

..... $ 315,000

Notwithstanding section 8.33, moneys appropriated in this subsection that remain unencumbered or unobligated at the close of the fiscal year shall not revert but shall remain available for expenditure for the purposes designated until the close of the fiscal year that begins July 1, 2010.

Senate File 478, section 160:

Sec. 160. COMPULSORY SCHOOL ATTENDANCE AGE == WORKING GROUP.

1. Of the amount appropriated from the human services reinvestment fund created in 2009 Iowa Acts, House File 820, if enacted, to the legislative services agency for the fiscal year beginning July 1, 2009, and ending June 30, 2010, $115,000 is transferred to the department of education to be used for costs associated with the working group convened pursuant to subsection 2.

2009 LEGISLATIVE HEALTH CARE COVERAGE COMMISSION

PUBLIC MEMBERS - VOTING

Health Care Provider
Dr. David Carlyle, Chairperson
McFarland Clinic P.C.
Ames, Iowa

Iowa Insurer Representative
Mr. Mike Abbott
American Enterprise Group
Des Moines, Iowa

Independent Insurance Agents Representative
Ms. Jennifer Browne
Benefit Source Inc.
West Des Moines, Iowa

Consumer Representing Low-income Adults and Families
Ms. Joan J. Jaimes
Marshalltown Community College
Marshalltown, Iowa

Labor Representative
Ms. Marcia Nichols
AFSCME IA Council 61
Des Moines, Iowa

Health Underwriter Representative
Mr. Joe Teeling
Bearence Management Group
West Des Moines, Iowa

Small Business Representative
Mr. Ted Williams
The Williams Group
Des Moines, Iowa

Consumer Representing Middle income Adults and Families
Ms. Betty Ahrens
Iowa City, Iowa

Large Employer Representative
Ms. Diane Crookham-Johnson
Musco Lighting Corporation
Oskaloosa, Iowa

Consumer Representing Pre Medicare Population
Mr. Bruce Koeppel
AARP
Des Moines, Iowa

Non Profit Representative
Mr. Tim Stiles
United Way of Siouxland
Sioux City, Iowa

EX-OFFICIO MEMBERS

Legislative Members

Senator Jack Hatch (D)

Senator David Johnson (R)

Representative Mark Smith (D)

Representative Linda Upmeyer (R)

Legislative Health Care Coverage Commission

Executive Members

Charles J. Krogmeier, Director
Department of Human Services

Susan Voss
Iowa Insurance Commissioner

Tom Newton , Director
Department of Public Health

Consultant to the Iowa Health Care Coverage Commission

Consultant: Limited one- to two-year contract: Pursuant to 2009 Iowa Senate File 389, this contractor will assist the Iowa Health Care Coverage Commission in developing an Iowa health care reform strategic plan. This contractor will coordinate commission activities, gather information relating to health reform, serve as liaison between stakeholders and the commission and between other levels of government and the commission, and write progress report and final report based upon commission deliberations. Perform other tasks as necessary for the commission to operate effectively. Extensive experience working with governmental entities and legislative bodies highly recommended. Advanced degree and extensive experience working on health care coverage reform policy development highly recommended. Ability to work independently as well as with legislative staff and others and to assimilate and balance ideas and directions from mUltiple authorities including the commission chair and vicechair, commission voting members and nonvoting legislative members, and legislative leadership. Ability to analyze policy options and to effectively communicate, compare and summarize complex policy concepts both orally and in writing. Compensation and terms negotiable. Please respond by 5:00 pm on July 17,2009 to House Speaker Pat Murphy, vice-chair, Iowa Legislative Council, at speaker@legis.state.ia.us.

Legislative Services Agency

Anne Kinzel
Commission Coordinator
515.233.5021

Legal Division

Patty Funaro
Senior Legal Counsel
515.281.3040

Ann Ver Huel
Senior Legal Counsel
515.281.3837

Caucus Staff

Senate Democrat Staff
Kris Bell
Senior Research Analyst
515.242.5804

Senate Republican Staff
Peter Matthes
515.281.3979

House Democrat Staff
Zeke Furlong
515.281.6972

House Republican Staff
Brad Trow
515.281.3979

PROPOSED RULES LEGISLATIVE HEALTH CARE COVERAGE COMMISSION*

1. Six of the voting members shall constitute a quorum, but a lesser number of members may adjourn or recess the Commission in the absence of a quorum.
2. A majority vote of those voting members present is necessary to carry any action.
3. Whenever Mason's Manual of Legislative Procedure does not conflict with the rules specifically adopted by the Commission, Mason's Manual of Legislative Procedure shall govern the deliberations of the Commission.
4. Meetings shall be set by motion before adjournment, or by call of the Chairperson of the Commission if meetings are necessary before the date set in the motion.
5. Rules shall be adopted by the affirmative votes of a majority of those voting members present and may only be changed or suspended by a similar vote of the Commission.
6. Each member of the Commission may designate one person to serve as an alternate and to attend and participate in Commission meetings and activities on that member's behalf when the member is absent. An alternate of a voting member of the Commission may vote on that member's behalf. A person serving as an alternate for a member shall be informed about the current activities of the Commission and shall be informed about and able to communicate the positions of the member for whom the alternate is serving. The designation of an alternate by a member must be received in writing by the Legislative Services Agency prior to the second meeting of the Commission.

Submitted: _____

***These rules were adopted by the Commission at its September 9, 2009 meeting.**

Iowa Employer Benefits Study©

About The Study:

David P. Lind & Associates, L.C. (DPL&A) has been conducting the annual ***Iowa Employer Benefits Study***© since 1999. For the past eleven years, this study has measured a statistically valid sample of urban and rural Iowa employers in all major industry groups. The recently released 2009 study was expanded to include a representative sample of employers with 2 to 9 employees due to a larger number of Iowa organizations within this size category. Understanding the need for relevant and credible data, DPL&A conducts research as a means to assist employers in making educated and informed decisions. The assimilation and dissemination of such research allows customers to understand the comparative value of their own benefit plans against a variety of norms. Throughout the years, this annual study has been utilized by the public to help assist policymakers regarding health care and health insurance reform in Iowa.

To avoid any potential outside influence, DPL&A engages an independent research firm, Data Point Research, Inc., for statistical expertise and guidance. In addition, this annual study is funded entirely by DPL&A.

About David P. Lind & Associates, L.C.:

As an independent, privately-held employee benefits consulting firm based in Clive, IA, DPL&A is committed to education, and serving employers with the planning, management, acquisition and compliance aspects of benefit plans. To complement its' consulting practice, DPL&A also conducts research to provide employers with pertinent information on benefit packages. The "2009 Iowa Employer Benefits Study" is the eleventh annual statistical review of Iowa employee benefits that is conducted annually. Founded in 1995, DPL&A is known as the leader in Iowa for employee benefits research and employee benefits consulting.

Professional Biography

David P. Lind, President

David P. Lind & Associates, L.C.

President and majority partner of David P. Lind & Associates, an employee benefits consultant and research firm based in Clive, Iowa.

Industry Experience:
Over 24 years experience in employee benefits.
Prior to founding David P. Lind & Associates in 1995, David served in the following positions:

- Account Consultant at Blue Cross and Blue Shield of Iowa;
- Group Specialist at Northwestern Group Marketing Services of Des Moines, Inc.

Education:
B.S. in Business Administration at Northeast Missouri State University.
Masters in Business Administration (MBA) at Drake University.

Professional Designation:
Certified Employee Benefit Specialist (CEBS), a designation provided through the International Foundation of Employee Benefit Plans and the Wharton School of Business (University of Pennsylvania).

Iowa Healthcare Coverage Commission

December 2, 2009

David P. Lind & Associates, LC
1350 NW 138th St. Ste. 400
Clive, IA 50325

(515)273-5140
www.DPLAConsulting.com
www.DPLABENCHMARK.com

DPL&A David P. Lind & Associates

2009 Iowa Employer Benefits Study©

11th Annual Study

David P. Lind & Associates, LC (DPL&A)

- At DPL&A, we are advisors and advocates for clients who desire to make informed decisions about their benefit plans. DPL&A serves employers with the planning, management, acquisition and compliance aspects of benefit plans.

Seal Of Approval

" The response rate of this study is 33.5 percent – 892 Iowa employers responded. For the overall sample, the employee-size weighted percentages are all accurate to within plus or minus 3.3 percent, at a 95 percent confidence level. "

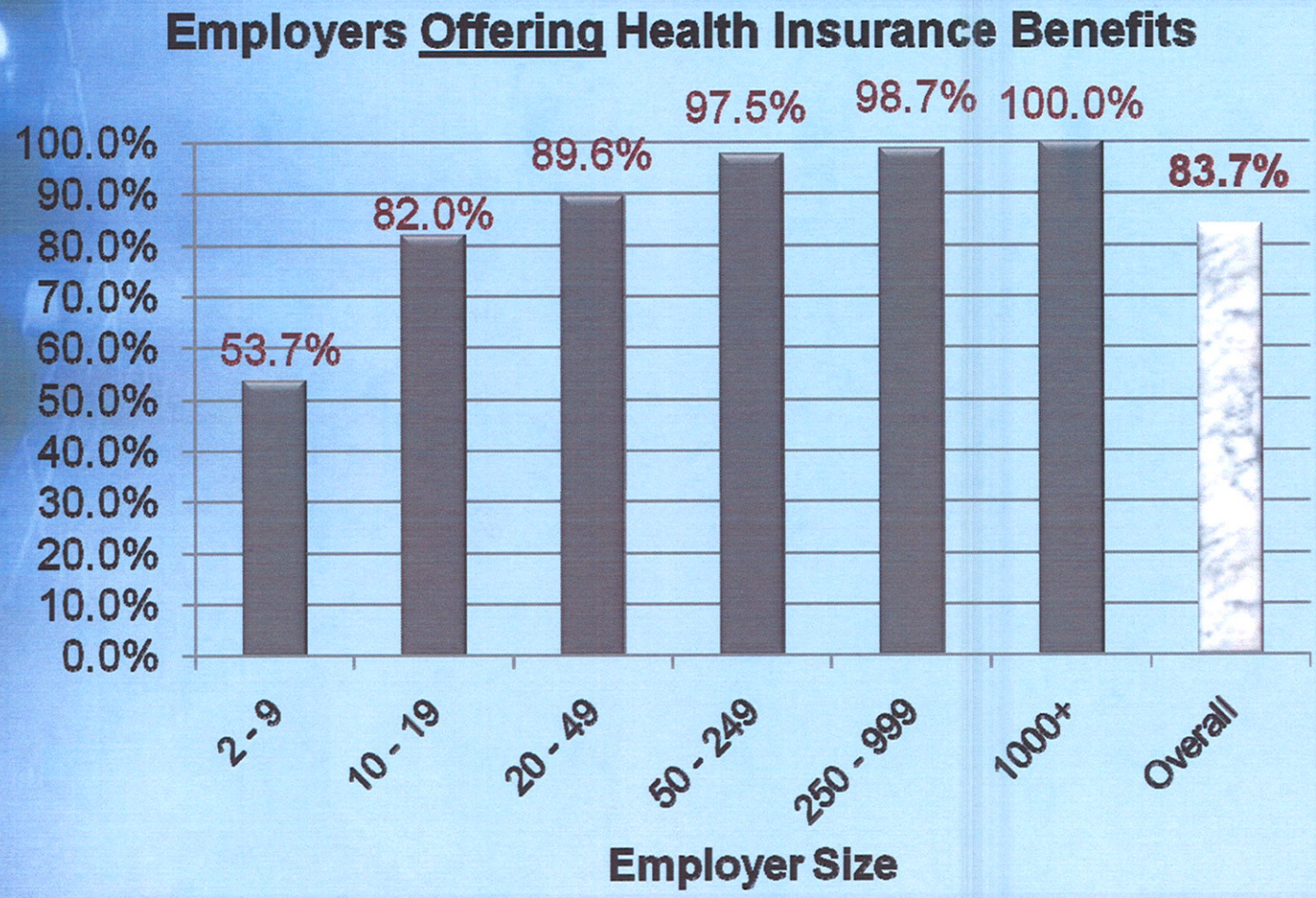
Data Point Research, *Inc*

DPL&A David P. Lind & Associates

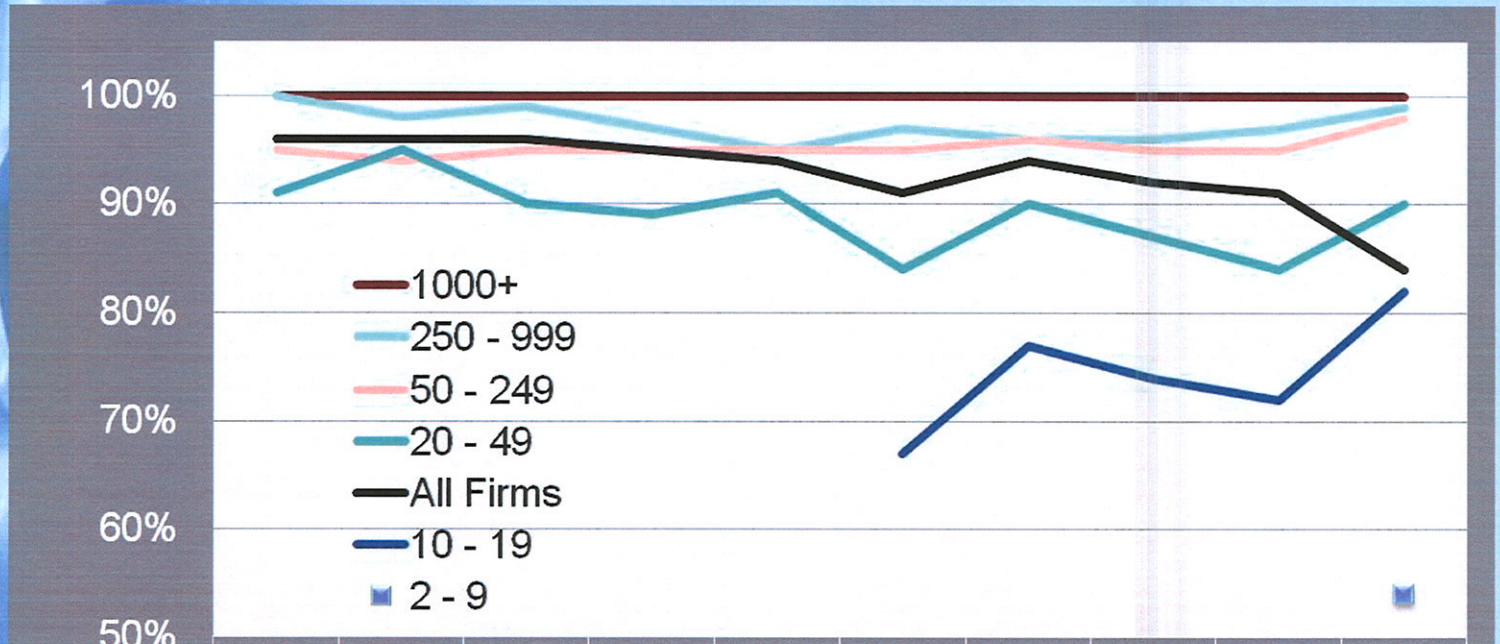
Iowa Employer Benefits Study©
Process: Population Characteristics

Employer Size	# of Employers in Group	# of Eligible Employers Sampled	# of Complete Interviews
2–9 Employees	135,561	560	156
10-19 Employees	7,077	342	128
20-49 Employees	4,485	628	193
50-249 Employees	2,435	879	286
250-999 Employees	385	179	89
1000+ Employees	77	72	28
TOTAL	**150,020**	**2,660**	**880**

Health Insurance in Iowa (2009)



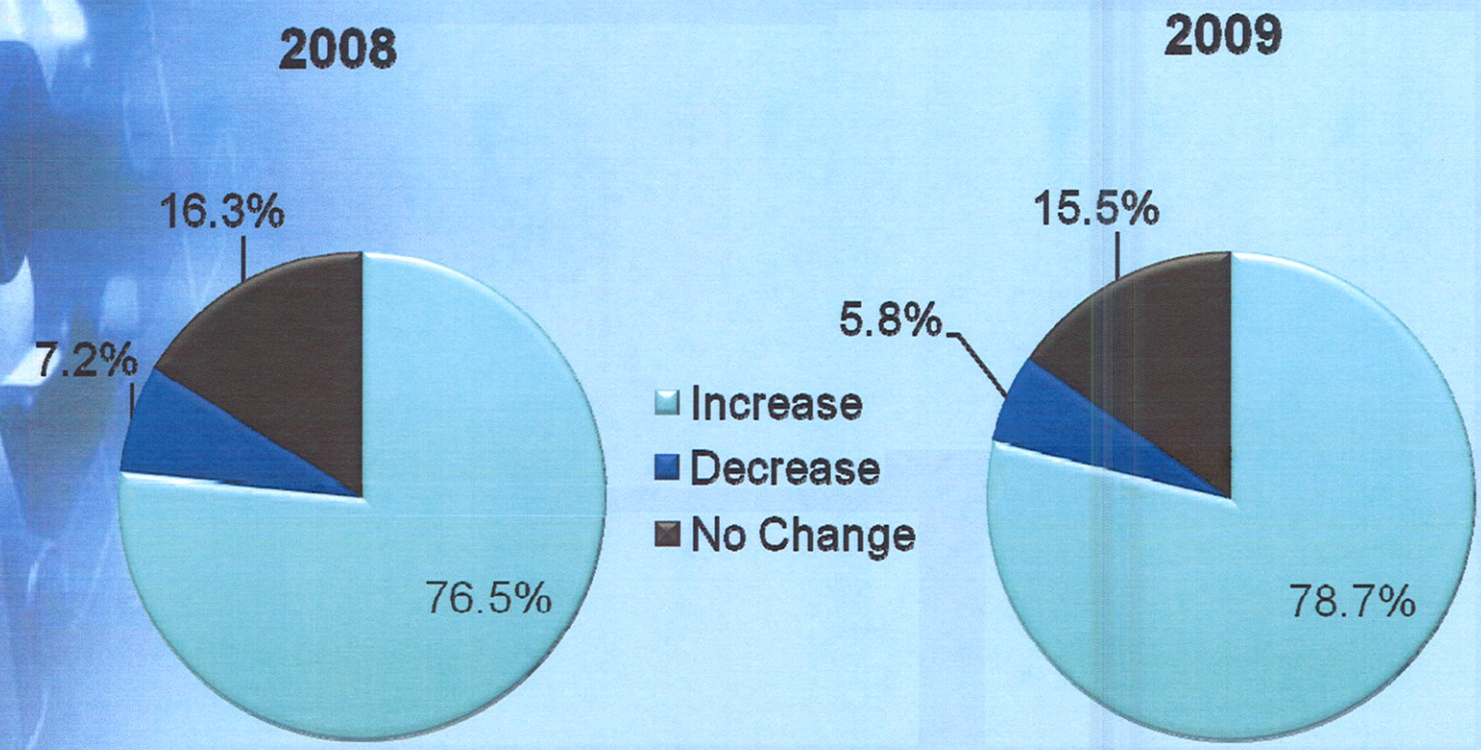
Percentage of All Firms Offering Health Benefits, By Size 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
1000+	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
250 - 999	100%	98%	99%	97%	95%	97%	96%	96%	97%	99%
50 - 249	95%	94%	95%	95%	95%	95%	96%	95%	95%	98%
20 - 49	91%	95%	90%	89%	91%	84%	90%	87%	84%	90%
All Firms	96%	96%	96%	95%	94%	91%	94%	92%	91%	84%
10 - 19						67%	77%	74%	72%	82%
2 - 9										54%

Source: Iowa Employer Benefits Study/DPL&A, 2000-2009

Average Health Insurance Rate Changes
2008 vs. 2009

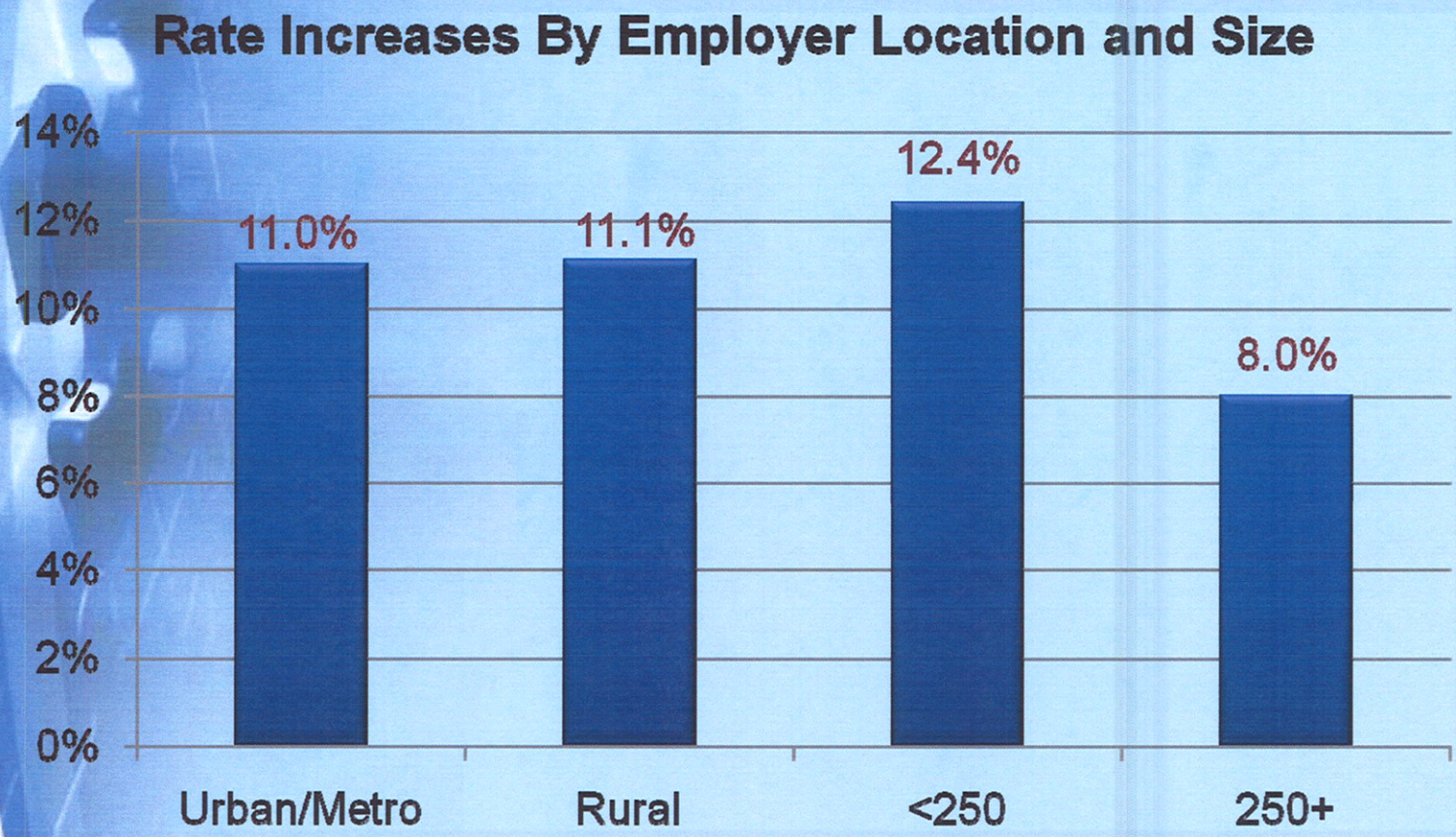


Average Health Insurance Rate Increases Reported in 2009

(Average Increase 10.7% without 2 to 9 category)

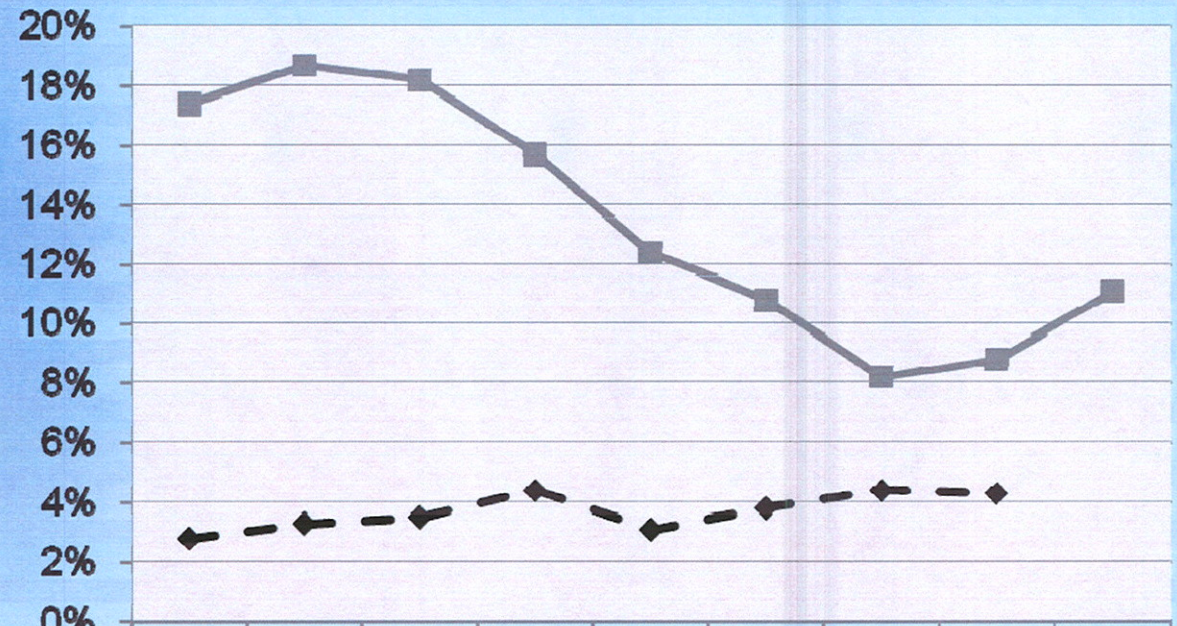
For All Employers, Regardless of Rate Direction	
Firm Size (Employees)	**Average % Increase 2009**
2 – 9	13.0%
10 – 19	15.8%
20 – 49	14.3%
50 – 249	10.3%
250 – 999	8.0%
1000 +	7.9%
Overall	***11.1%***

Average Health Insurance Rate Impact Reported in 2009



For All Employers, Regardless of Rate Direction

Average Health Insurance Rate Increases Compared to Statewide Average Weekly Wage Increases 2001 to 2009



	2001	2002	2003	2004	2005	2006	2007	2008	2009
IWD Weekly Wage Increase	2.8%	3.3%	3.5%	4.4%	3.1%	3.8%	4.4%	4.3%	N/A
Average Premium Increase	17.4%	18.7%	18.2%	15.7%	12.4%	10.8%	8.2%	8.8%	11.1%

Weekly Wage Increase Percentages Provided by Iowa Workforce Development

2009 Medical Plan
Monthly Premiums by Size (All Plans)

Single Premiums

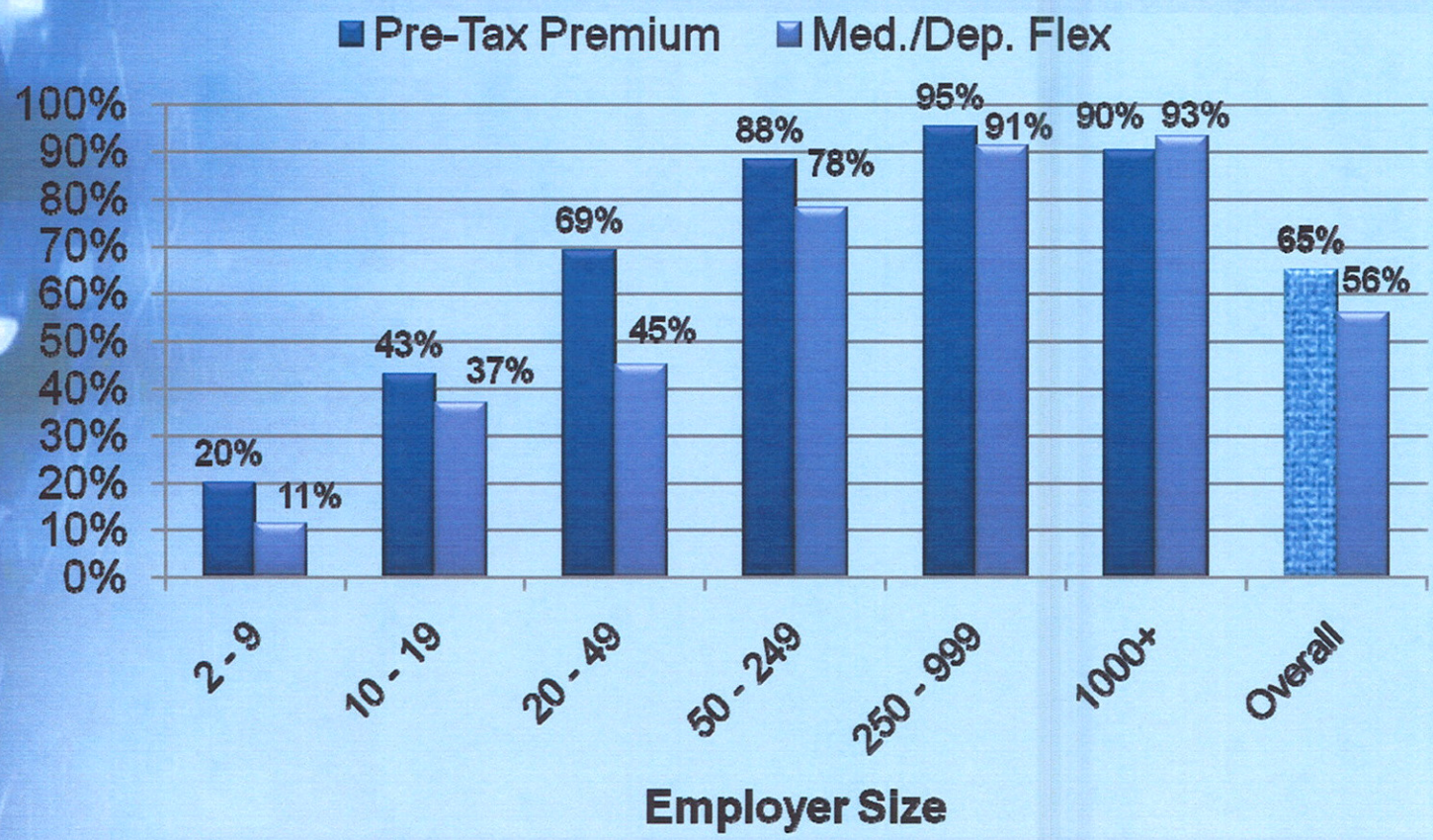
	2-9	10-19	20-49	50-249	250-999	1000+	Weighted Average
Total	$413	$363	$334	$353	$386	$383	$370
Employee	$54	$59	$71	$66	$70	$59	$65
Employer	$358	$303	$263	$287	$316	$324	$305

2009 Medical Plan
Monthly Premiums by Size (All Plans)

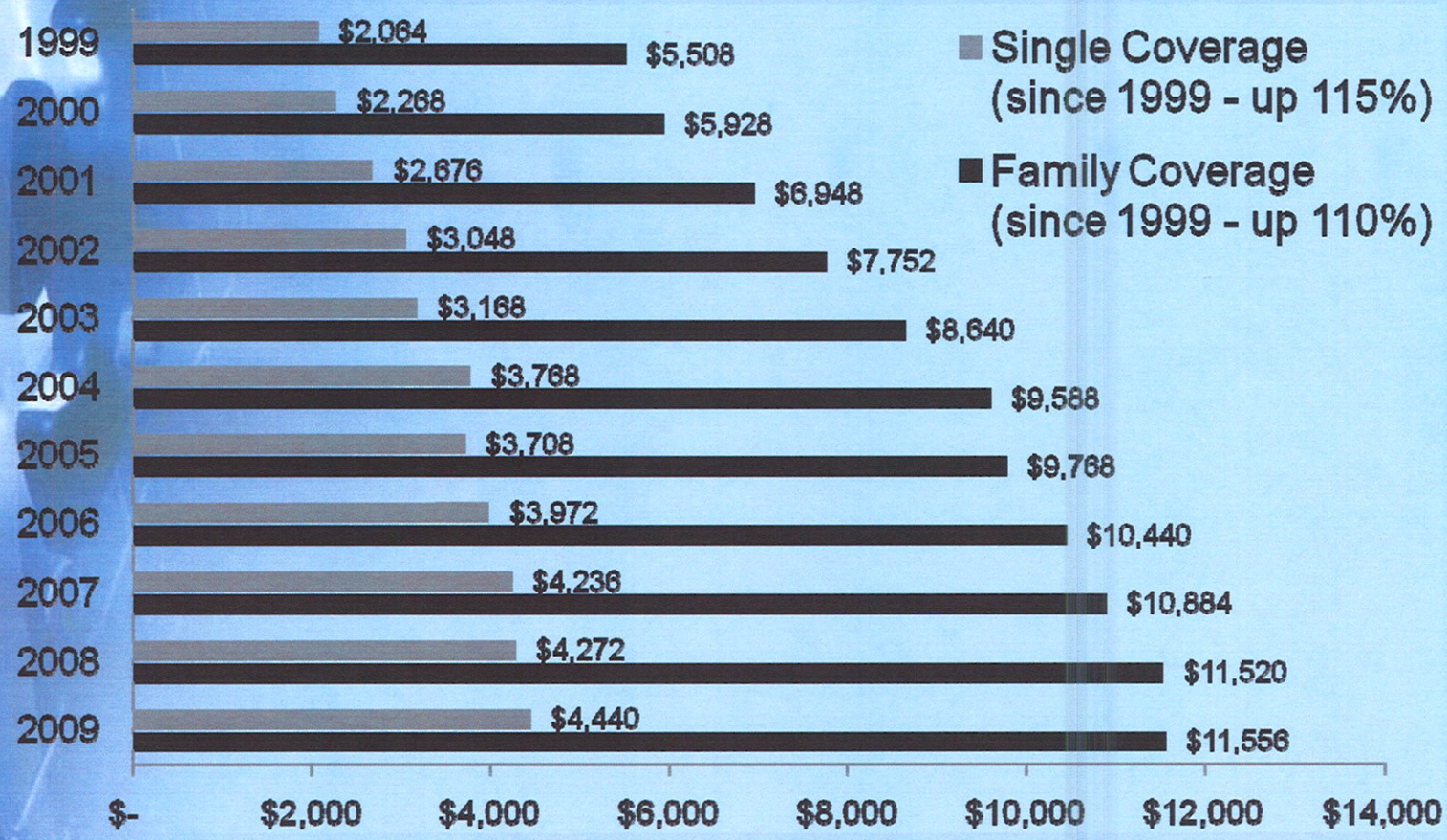
Family Premiums

	2-9	10-19	20-49	50-249	250-999	1000+	Weighted Average
Total	$1,024	$884	$900	$923	$1,015	$1,059	$963
Employee	$271	$346	$414	$302	$343	$229	$319
Employer	$753	$538	$486	$620	$671	$829	$644

Prevalence of Section 125 Plans
(By Employer Size)



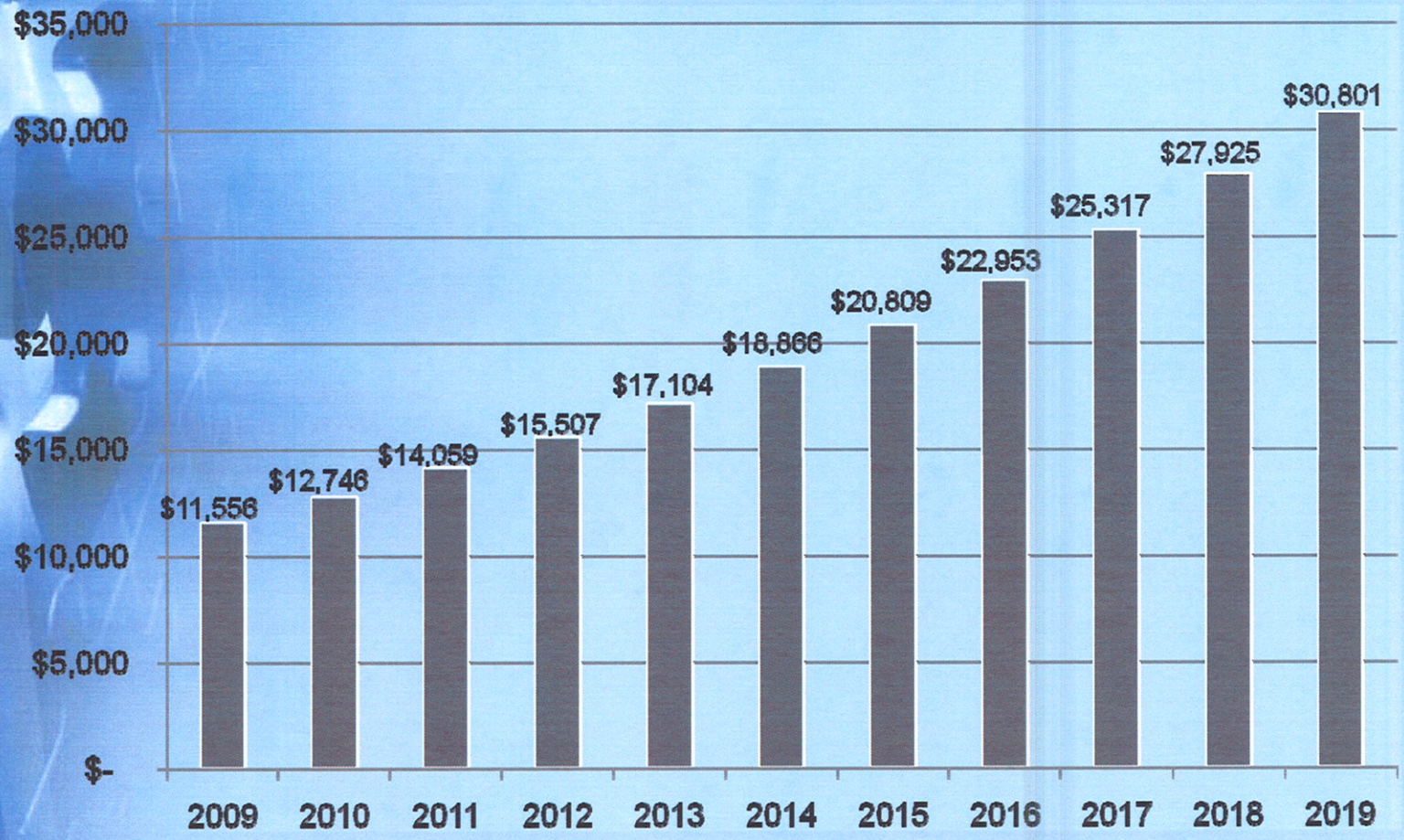
Average Annual Premiums for Single and Family Coverage, 1999-2009 (All Plans Combined)



Source: Iowa Employer Benefits Study/DPL&A, 1999-2009

Illustrative Health Insurance Premium Projections for Family Coverage

Assuming Average Growth Rate of 10.3% from 2005-2009



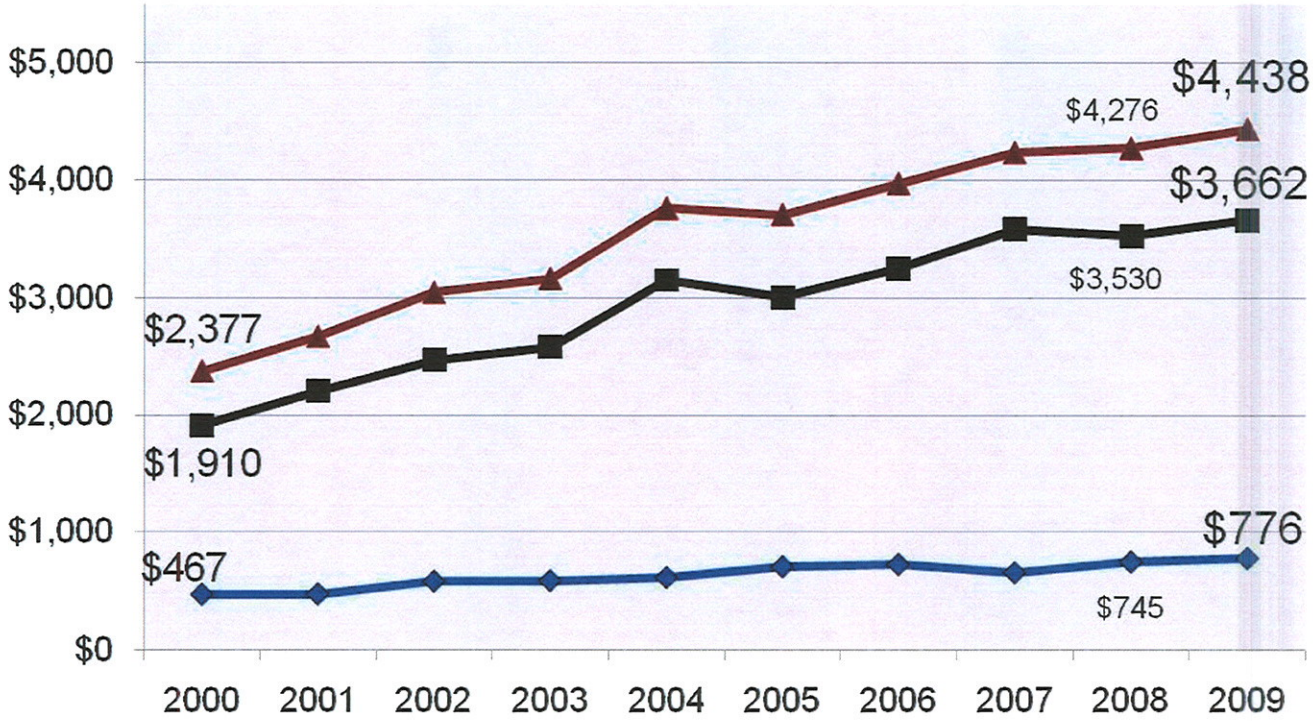
Note: Health insurance premiums projected for 2010-2019 assuming that the average growth in premiums between 2005 and 2009 (10.3% before benefit plan changes were made) continues.

Source: Iowa Employer Benefits Study/DPL&A, 2005-2009

Rate History
All Medical Plans Combined

(HMO, PPO, Traditional Indemnity, HSAs)

Annual Single Medical Contributions



Total Premium ⬆ 87%

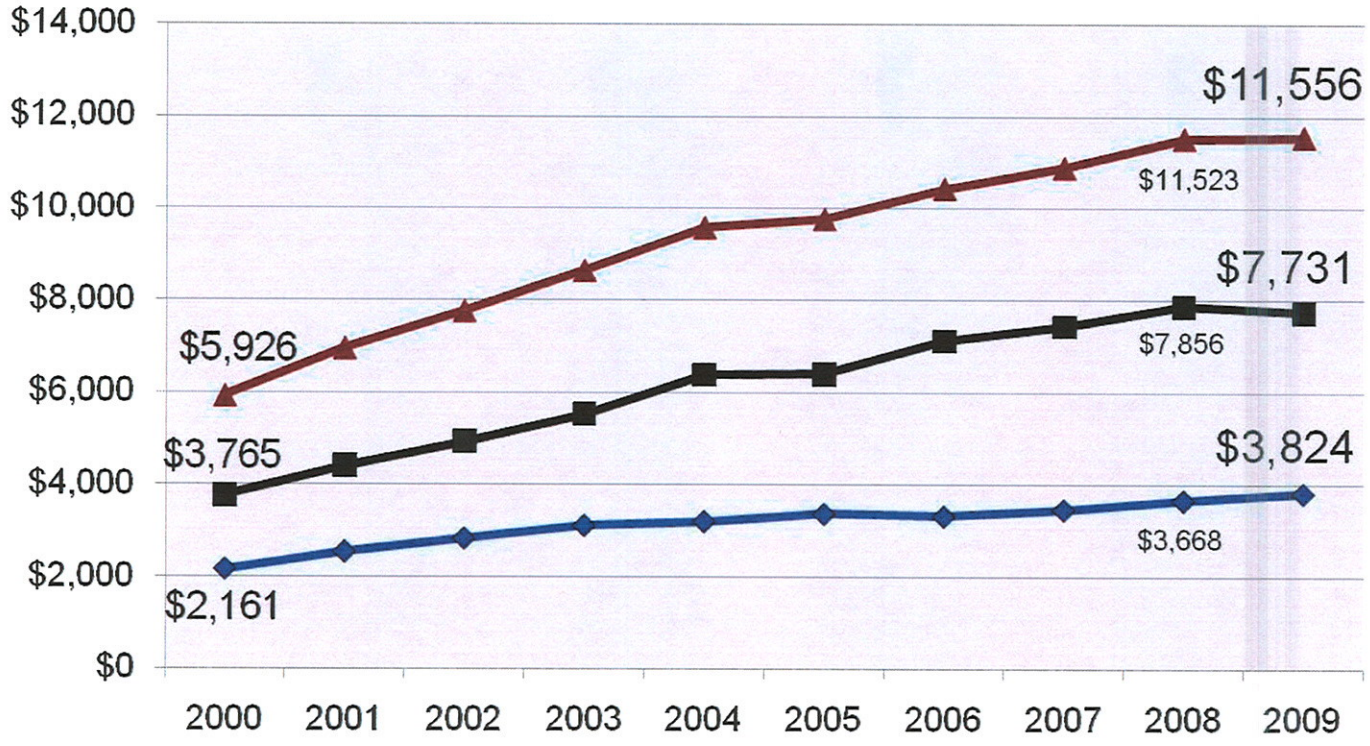
Employer Contribution ⬆ 92%

Employee Contribution ⬆ 66%

Rate History
All Medical Plans Combined

(HMO, PPO, Traditional Indemnity, HSAs)

Annual Family Medical Contributions



Total Premium ⬆ 95%

Employer Contribution ⬆ 105%

Employee Contribution ⬆ 77%

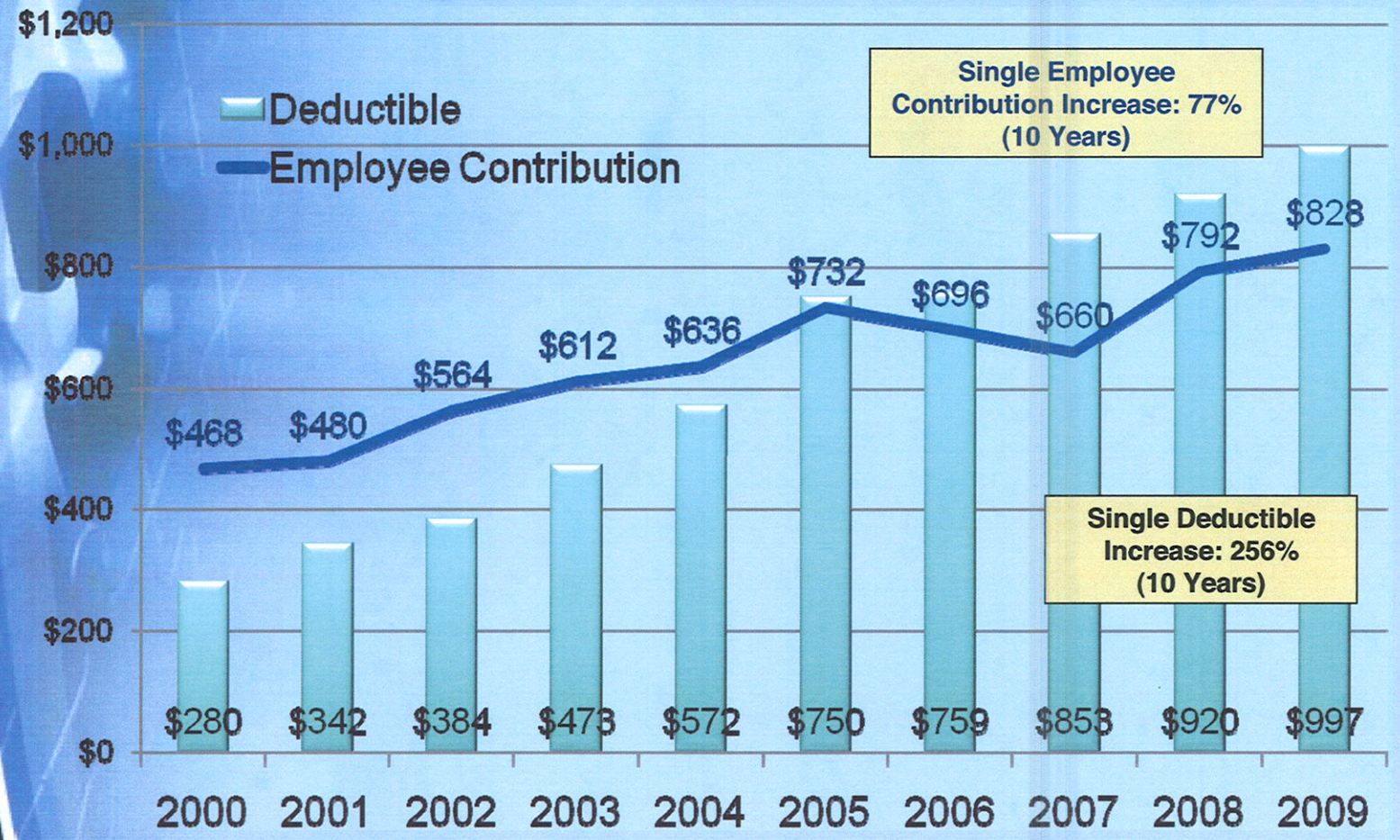
Employer Responses to Health Insurance Rate Increases Reported in 2009

- *Here is what employers say they DID do…*
  - *60% Passed some or all of increased costs to employees*
  - *26% Raised deductibles*
  - *18% Organization absorbed the entire cost increase*
  - *17% Raised out of pocket maximum*
  - *16% Increased office call copays*
  - *14% Increased prescription drug copays*
  - *10% Changed Insurance Companies*
  - *9% Reduced pay raises or bonuses*
  - *8% Other*
  - *5% Postponed capital improvements*
  - *5% Began wellness/disease management initiatives*
  - *4% Hired fewer new employees*
  - *2% Offered CDHP*
  - *2% Released employees*
  - *1% Began surcharge for covered spouse under employee policy*
  - ***0.1% Stopped providing health insurance coverage***

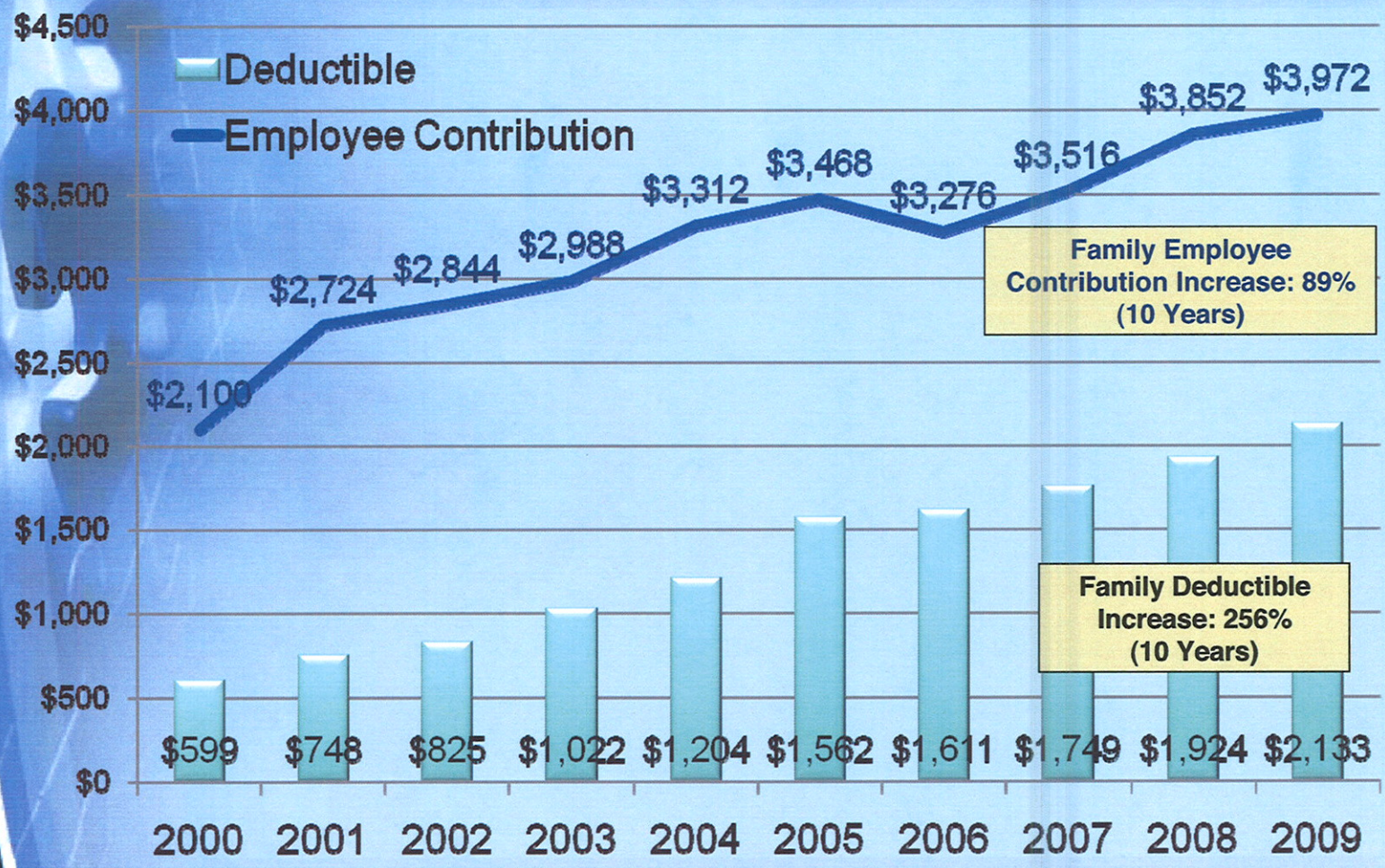
Employer Responses to Health Insurance Rate Increases Reported in 2009

- *Here is what employers say they DID do…* ***(Employer Size 2 – 9 in Red)***
  - *60% Passed some or all of increased costs to employees (**36%**)*
  - *26% Raised deductibles (25%)*
  - *18% Organization absorbed the entire cost increase (**30%**)*
  - *17% Raised out of pocket maximum (13%)*
  - *16% Increased office call copays (16%)*
  - *14% Increased prescription drug copays (12%)*
  - *10% Changed Insurance Companies (**15%**)*
  - *9% Reduced pay raises or bonuses (**18%**)*
  - *8% Other (5%)*
  - *5% Postponed capital improvements (**10%**)*
  - *5% Began wellness/disease management initiatives (**0%**)*
  - *4% Hired fewer new employees (5%)*
  - *2% Offered CDHP (0%)*
  - *2% Released employees (3%)*
  - *1% Began surcharge for covered spouse under employee policy (2%)*
  - ***0.1% Stopped providing health insurance coverage (0%)***

Deductible and Contribution
Single Coverage (PPO Only)

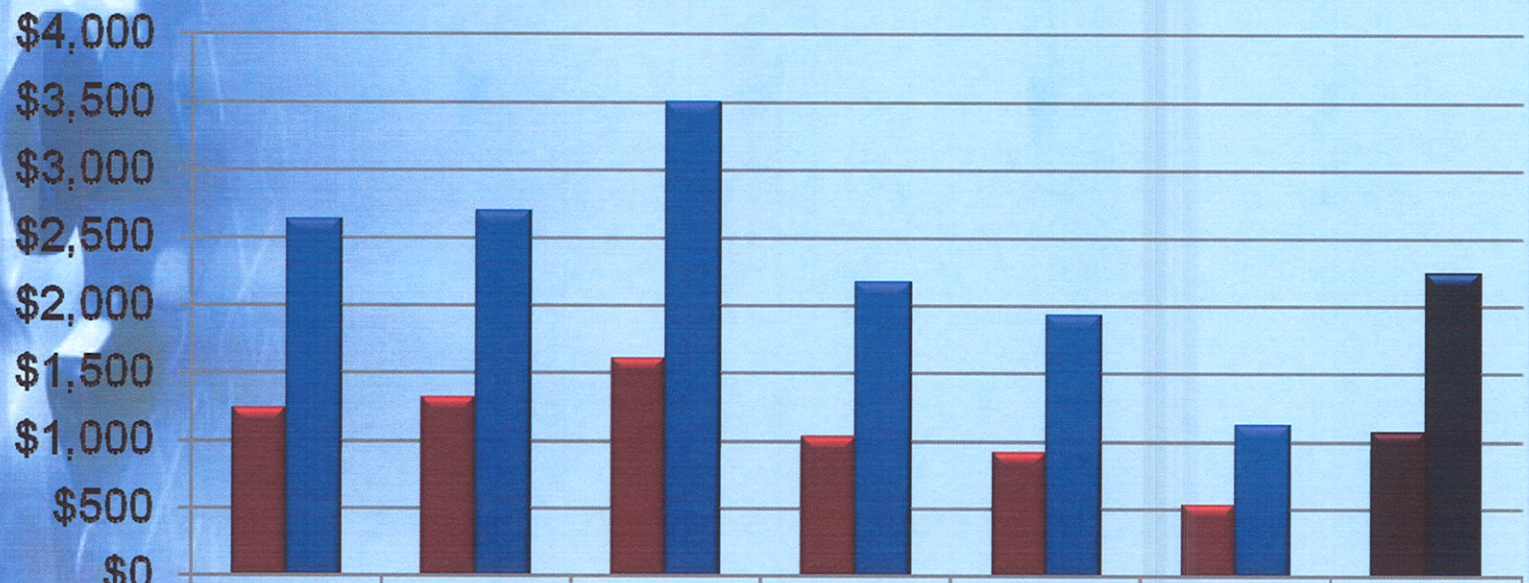


Deductible and Contribution
Family Coverage (PPO Only)



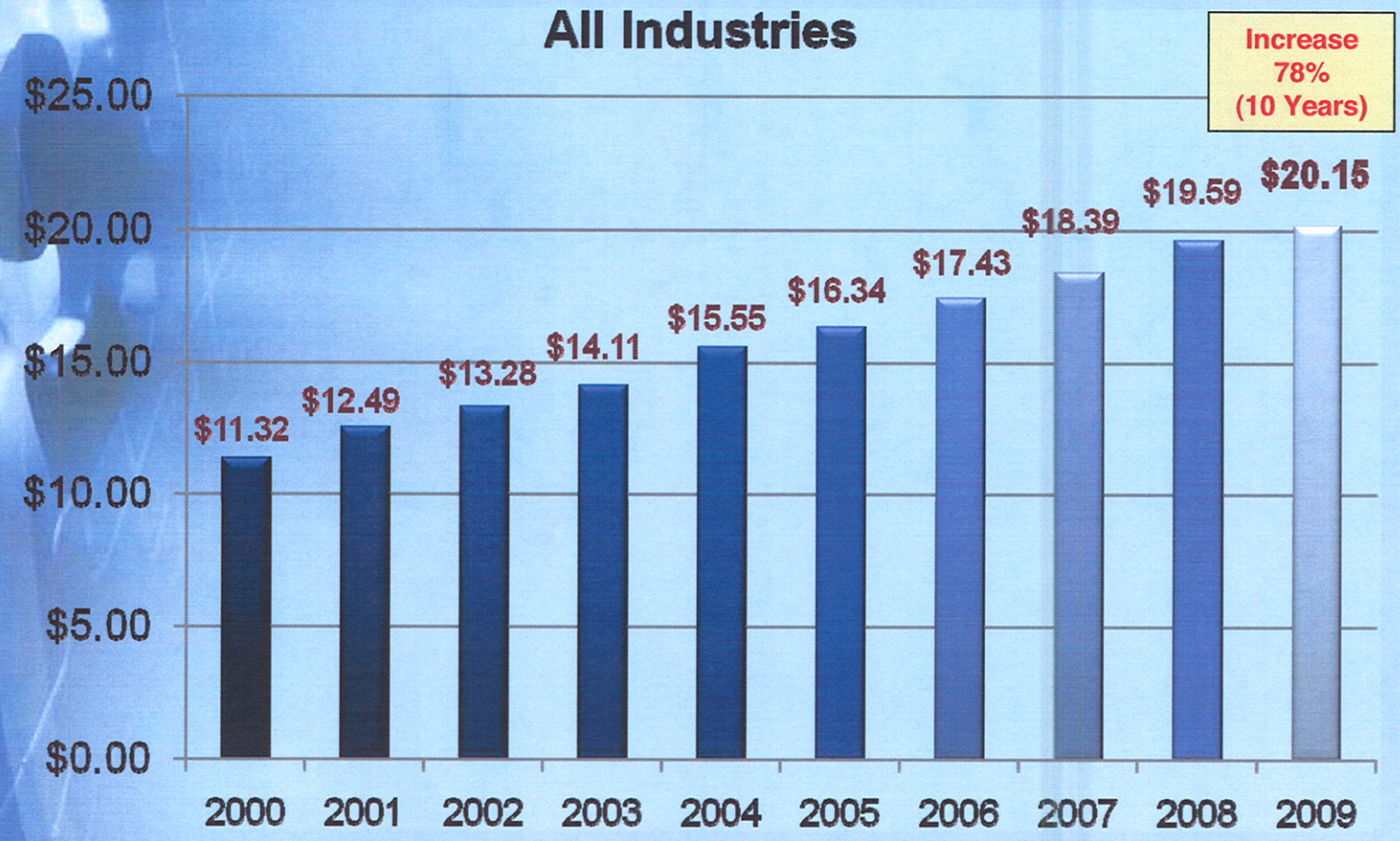
2009 Medical Plan
In-Network Deductibles (All Plans)

Deductibles By Employer Size in 2009



	2 - 9	10 - 19	20 - 49	50 - 249	250 - 999	1000 +	Weighted Average
Single	$1,233	$1,315	$1,604	$1,029	$911	$529	$1,061
Family	$2,622	$2,689	$3,496	$2,159	$1,924	$1,113	$2,230

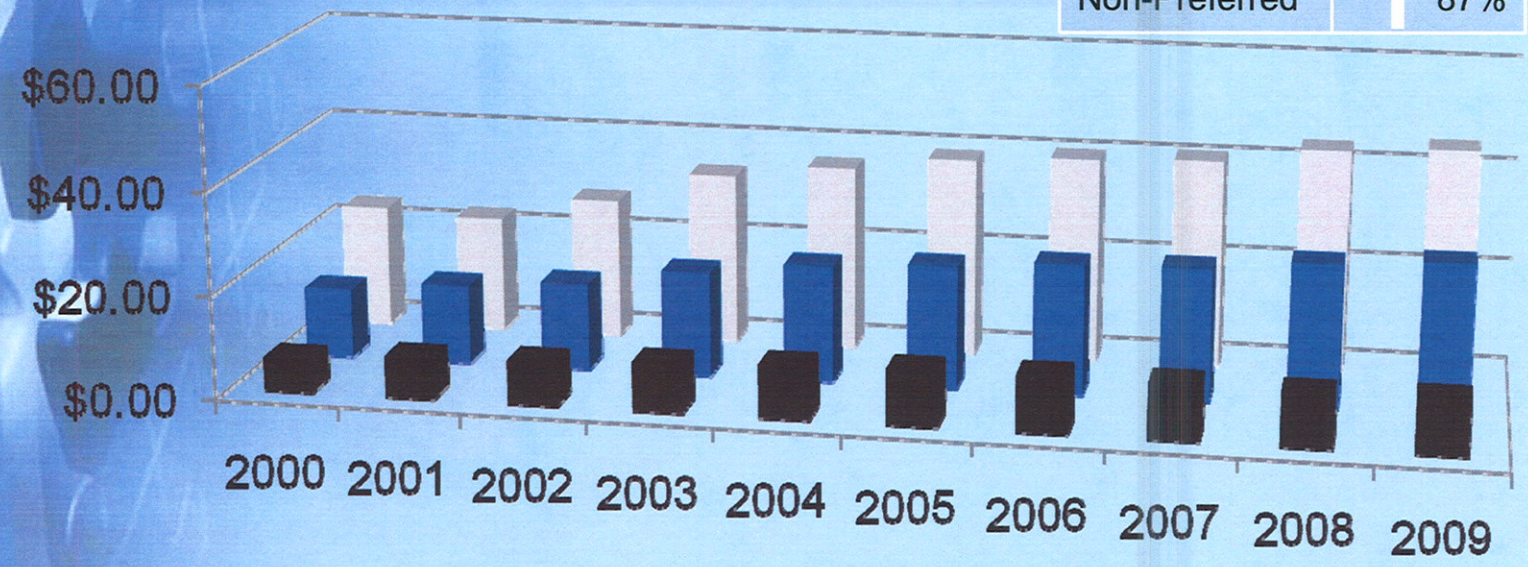
Medical Plan
Office Copays (PPO Only)



Medical Plan RX Copays

(PPO Only)

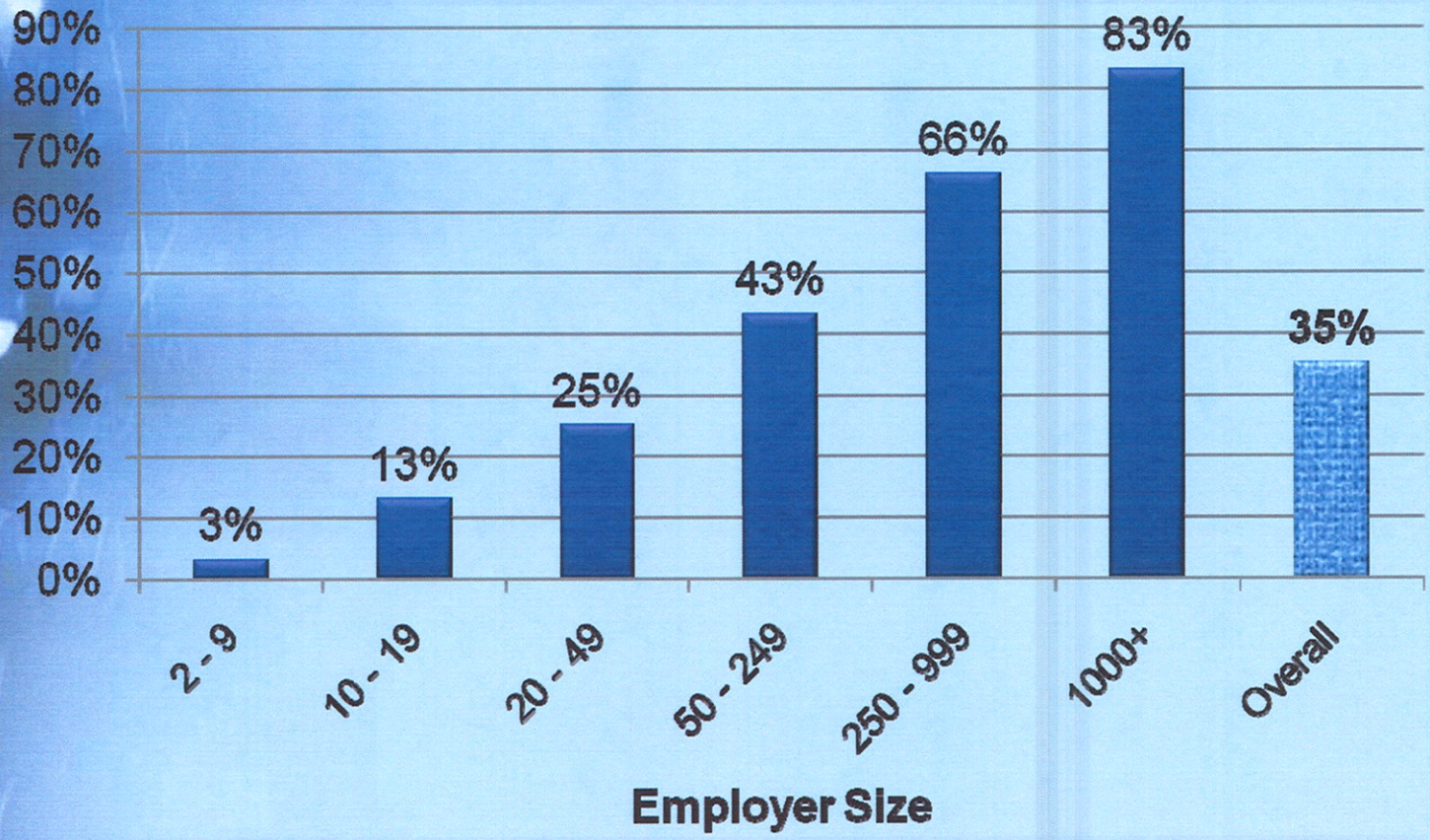
10 Years	
Generic	↑ 58%
Preferred	↑ 114%
Non-Preferred	↑ 87%

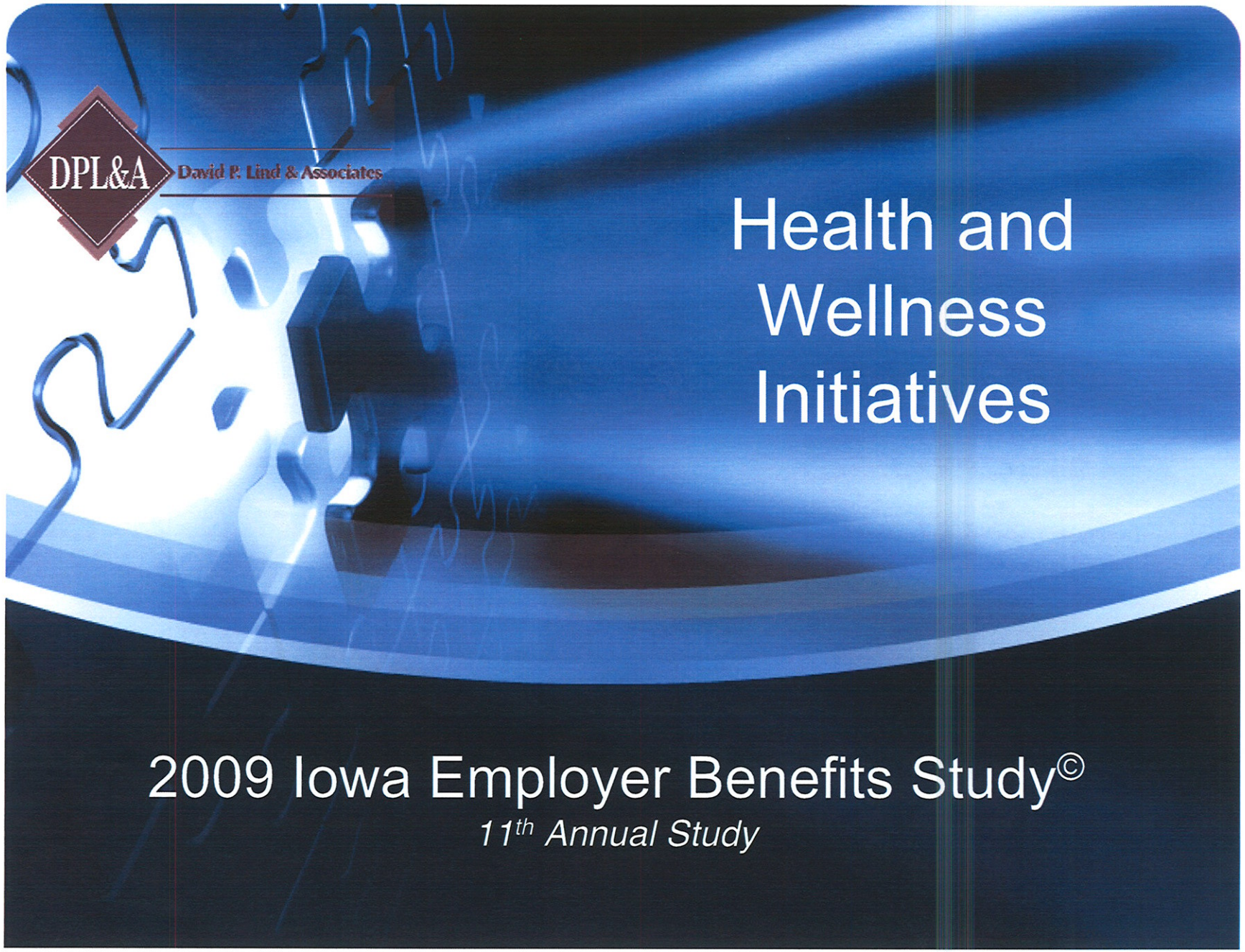


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Generic	$6.58	$7.98	$8.45	$9.48	$10.28	$10.75	$10.92	$10.74	$10.26	$10.40
Preferred, Brand Name	$13.46	$15.39	$16.86	$20.29	$22.70	$23.80	$25.18	$25.63	$27.64	$28.87
Non-Preferred, Brand Name	$23.91	$22.71	$27.42	$33.58	$36.12	$38.72	$39.89	$40.57	$43.59	$44.64

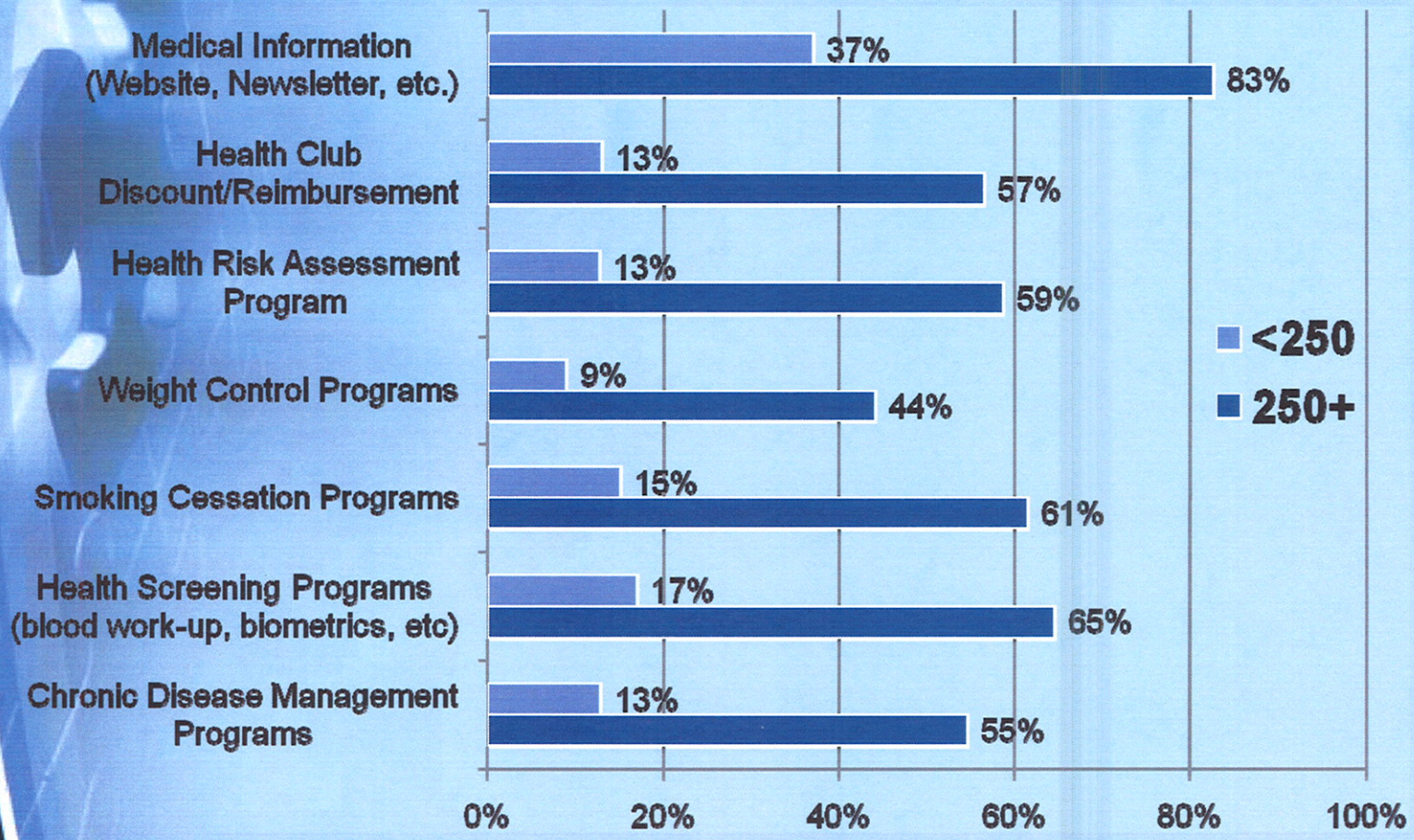
Prevalence of Vision Coverage

(By Employer Size)



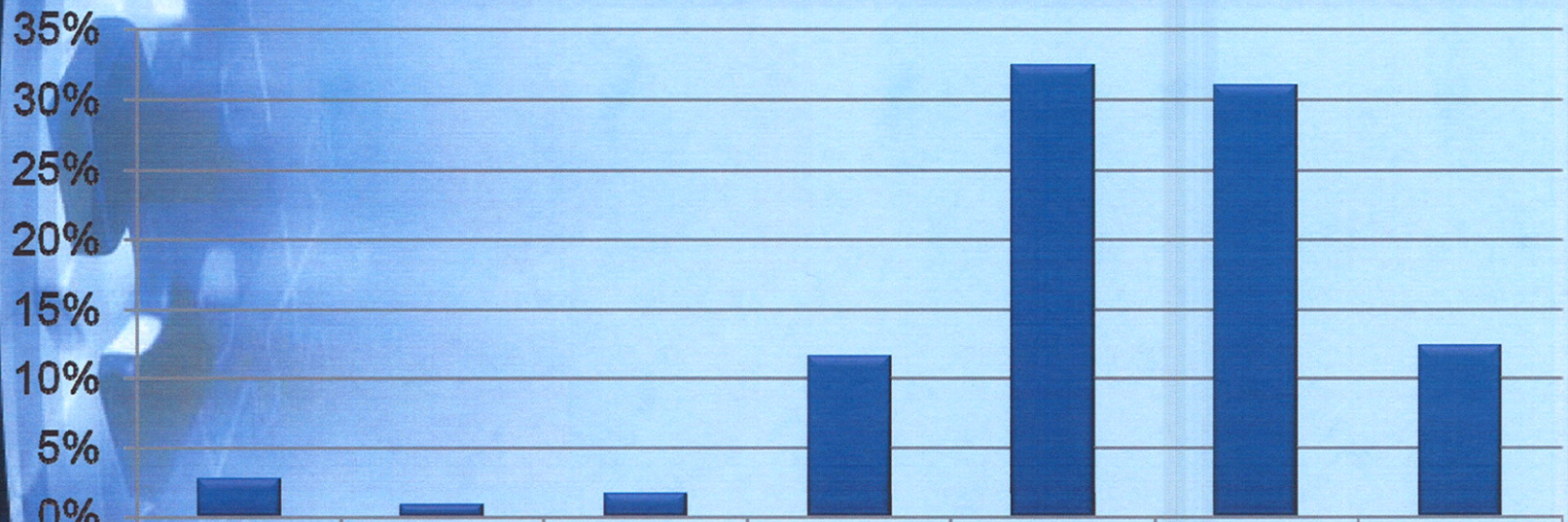

DPL&A
David P. Lind & Associates
Health and Wellness Initiatives
2009 Iowa Employer Benefits Study©
11th Annual Study

Employers Offering Wellness Initiatives
(Based on Employer Size)



Source: Iowa Employer Benefits Study/DPL&A, 1999-2009

Percentage of Employers Offering Incentives to Encourage Healthy Behaviors



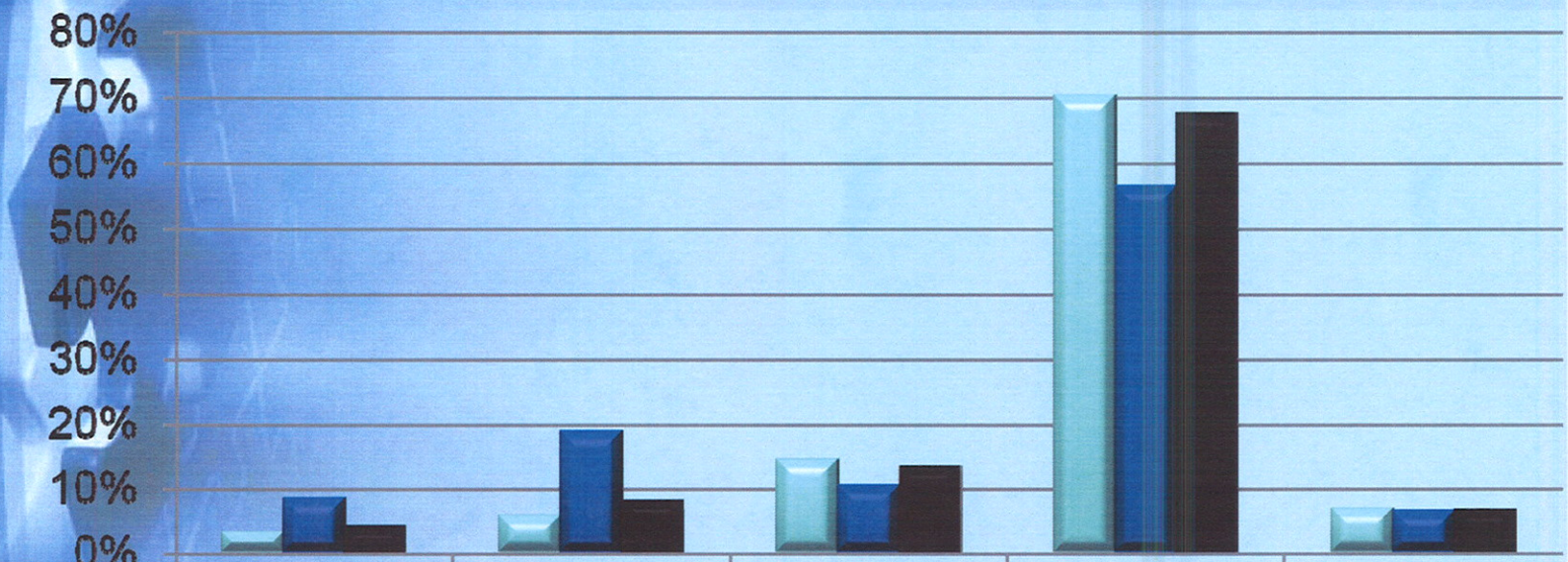
	2-9	10-19	20-49	50-249	250-999	1000+	Overall
2009	2.7%	0.8%	1.6%	11.6%	32.4%	31.0%	12.3%

Employer Size

All Industries - 2009

Likelihood of Offering Incentives to Encourage Healthy Behaviors in the Next Year

(Based on responses from employers that do not currently offer incentives)



	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely	Not Sure
<250	3.1%	5.6%	14.3%	70.2%	6.8%
250+	8.3%	18.7%	10.3%	56.3%	6.3%
Overall	4.1%	8.1%	13.5%	67.5%	6.7%

All Industries - 2009

2009 Iowa Employer Benefits Study©

11th Annual Study

Questions?

Contact:

David Lind

800-821-5463

or

David@dplaconsulting.com

www.dplaconsulting.com

WORKGROUP 1 COVERAGE OF ADULTS
QUARTERLY PROGRESS REPORT

- **Members**
  Dr. David Carlyle (Chair)
  Ms. Betty Ahrens
  Ms. Diane Crookham-Johnson
  Mr. Bruce Koeppel
  Mr. Charles Krogmeier (Ex-Officio) Iowa Medicaid Director Ms. Jennifer Vermeer attended the meetings as Director Krogmeier's alternate.

- **Workgroup Web Page**
  www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=506

- **Charge**

At the Commission's meeting on September 9, 2009, Commission Chair David Carlyle presented the following charge to Workgroup 1**:**

> Workgroup 1 is tasked to review, analyze, recommend, and prioritize options to offer health coverage to uninsured and underinsured adults in the state, by doing the following, including, but not limited to:
>
> A. Presenting options for subsidized and unsubsidized health care coverage programs which offer public and private, adequate and affordable health care coverage, including, but not limited to, options to purchase coverage with varying levels of benefits including basic catastrophic benefits, an intermediate level of benefits, and comprehensive benefits coverage.
>
> (1) Including options for providing an array of benefits that may include physical, mental, and dental health care coverage.
>
> (2) Including development of health care coverage options for purchase by adults and families with the goal of including options for which the contribution requirement for all cost sharing expenses is no more than 6 and one-half percent of family income.
>
> B. Analyzing the ramifications of requiring each employer in the state with more than ten employees to adopt and

maintain a cafeteria plan that satisfies §125 of the Internal Revenue Code.

- **Workgroup Meetings and Focus**
  Workgroup 1 met on four occasions in the fall of 2009:

  - **September 28**
    Discussion of IowaCare and hawk-i programs with presentations by Jennifer Vermeer, DHS and Anita Smith, DHS.
  - **October 12** (Telephonic meeting)
    Focused discussion of potential for IowaCare expansion.
  - **November 9**
    Presentations on IowaCare by University of Iowa Hospitals and Clinics (UIHC), Iowa Nebraska Community Primary Care Association (IANEPCA) (community health centers), Broadlawns Medical Center, and the Iowa Hospital Association representatives.
  - **November 23**
    Presentation on IowaCare expansion by Jennifer Vermeer (DHS) and preparation of recommendations for the January 1, 2010 Commission quarterly progress report.

The meetings were held either at the AARP state headquarters (600 E. Court Ave., Des Moines, Iowa) and via telephone conference. Notice of the meetings was provided to the the public on the Commission's web site (www.legis.state.ia.us/Current/Interim). In addition, a telephone call in number was provided for telephonic meetings. A majority of workgroup members attended each of the meetings.

Background

IowaCare

Representatives from the University of Iowa Hospitals and Clinics (UIHC) shared information on the level of subsidy provided by UIHC to the IowaCare program and on wait times for Iowa Care enrollees.

FY 2009 University Hospital & Clinic & University of Iowa Physician (UIP) and the IowaCare Program	
Total IowaCare Patients (Representing 98 counties) (Approx. 80% had incomes below 100% of FPL)	33,000
UIHC Cost of Serving IowaCare Population (Including voluntary services)*	$87,241,821
UIHC IowaCare Reimbursement	-$57,060,391

FY 2009 University Hospital & Clinic & University of Iowa Physician (UIP) and the IowaCare Program	
UIHC Subsidization of IowaCare	**$30,181,430**
University of Iowa Physicians (UIP) Cost of Serving IowaCare Population	$20,961,317
UIP IowaCare Reimbursement	$0
UIP Subsidization of IowaCare	$20,961,317
Total University of Iowa Health Care Subsidization of IowaCare	**$51,142,747**
Voluntary services provided by UIHC include $4,870,535 for the pharmaceutical assistance pilot program; $1,098,861 for transportation; $612,242 for the IowaCare Assistance Center; $966,330 for the durable medical equipment pilot program $253,436 spent on expedited discharges; and $224,162 spent on placing IowaCare patients in nursing facilities and inpatient rehabilitation centers for post-hospital care. Source: UIHC	

UIHC IowaCare Wait Times. Currently, a new IowaCare patient with no significant medical needs can expect to wait several months to get an appointment at UIHC. Accordingly, UIHC provides triage services to assure that IowaCare patients in need of more timely services will be seen sooner. Due to the demand for specialized services at UIHC all Iowans seeking care can expect to face delays in obtaining appointments in the absence of pressing medical needs.

Broadlawns Medical Center (Polk County)

Representatives from Broadlawns Medical Center presented information to the Workgroup on Broadlawns' involvement with the IowaCare program. Broadlawns served approximately 13,000 IowaCare patients in 2009. Broadlawns enrolls IowaCare patients as primary care patients in "medical homes" and provides mental health care services to IowaCare enrollees. Broadlawns has a limited capacity to provide advanced medical services to IowaCare patients, and currently has no capacity to provide orthopedic, cardiac or vascular care. About 90 Broadlawns IowaCare patients are referred to UIHC every month for more advanced care.

National Health Care Reform

The Workgroup has followed the U.S. Congress' health care reform efforts, including bills that have emerged from the House and the Senate. Workgroup 1 has a strong sense that, beginning in 2014, the Medicaid program will be expanded to provide eligibility to persons with income levels up to either 133 percent or 150 percent of the Federal Poverty Level. Expansion will also provide eligibility to include adults without dependent children. Federal reform also includes potential increases in the the federal

medical assistance percentage (FMAP) which will reduce Iowa's fiscal burden in providing coverage to newly eligible populations.

These changes, along with many others that may emerge should a health care reform bill be signed by the President in 2010, will create a vastly different terrain for expanding access to health care across Iowa which the Workgroup believes will provide new opportunities for providing new public and/or private coverage to low income Iowans. At the same time the Workgroup does recognize that it is currently somewhat limited in its ability to prepare recommendations due to the uncertainty surrounding federal health care reform efforts.

RECOMMENDATIONS

The Workgroup's initial recommendations are focused on helping the state expand coverage between now and 2014, and to prepare Iowa to take advantage of the new opportunities that national level reform can provide.

Recommendation 1: Expand IowaCare.
Expand IowaCare to create a regional delivery model that will provide access to primary care and hospital care in the least geographically burdensome manner, which is defined as providing all but tertiary level care as close as possible to an IowaCare member's home.

As a result the current limited IowaCare provider network will expand beyond Broadlawns Hospital in Polk County and the University of Iowa Hospitals and Clinics and the estimated (2006) 52 percent of uninsured Iowans with incomes below 200 percent of the Federal Poverty Level will have significant new opportunities to access important health care services.[1]

The future of IowaCare is in large part dependent on the ultimate outcome of federal health care reform. Even if federal health care reform does come about and provide new coverage opportunities for low income adult Iowans, IowaCare will need to provide access to care until federal reform becomes operational, in 2014 at the earliest. The Workgroup anticipates many IowaCare enrollees will become part of an expanded, post-reform, Medicaid population and believes that an immediate expansion of the IowaCare network can help IowaCare enrollees and providers successfully transition to an expanded Medicaid program.

As part of an an IowaCare expansion, the Iowa Care benefits package should be amended to include a limited pharmacy benefit.

[1] Eathington, L. (August 14, 2009). *Health Insurance Coverage Estimates for Iowa. Department* of Economics: Iowa State University.

Furthermore, an IowaCare regional model expansion should include provisions that will require IowaCare participating providers to continue to provide a reasonable level of uncompensated care.

The Workgroup is aware that a regional IowaCare expansion model, as suggested by the Iowa Department of Human Services, the University of Iowa Hospitals and Clinics, and Broadlawns Hospital, is at a very early stage of development and the Workgroup is committed to providing input to aid in the continued design of this expansion model.

Recommendation 2: Fund increases in DHS technological capacities.
In anticipation of federal health care reform, the Department of Human Services needs to receive increased technology funding, including funding to provide for electronic eligibility determination and processing. The Department also needs to be aggressive in pursuing opportunities from the federal government to implement new technological approaches for determining Medicaid eligibility and enrollment mechanisms.

Recommendation 3: Iowa should pursue federal health care reform early opt-in opportunities. Iowa has a strong history of taking on a leadership role in health care access reform. If the federal government provides useful incentives for early adoption of measures that can increase access to affordable health care, the Workgroup recommends that Iowa move aggressively in pursuing these opportunities before 2014.

Recommendation 4: The Workgroup supports the development of a statewide diabetic registry. In order to improve care of uninsured diabetic patients and begin the process leading to upcoming Medicaid expansion, the state should set up a diabetic registry with the assistance of Iowa's Community Health Centers and free medical clinics, which in exchange for data and lab tests will provide a basic combination of medications, including anti-hypertensives, cholesterol lowering agents, and diabetic medications.

WORKGROUP 2 USE/CREATION OF STATE POOL
QUARTERLY PROGRESS REPORT

- **Members**
  Ms. Marcia Nichols (Chair)
  Mr. Tim Stiles
  Mr. Joe Teeling
  Ms. Susan Voss, Iowa Insurance Commissioner (Ex-Officio)

- **Workgroup Web Page**
  http://www.legis.state.ia.us/Current/Interim

- **Charge**
  At the Commission's meeting on September 9, 2009, Commission Chair David Carlyle presented the following charge to Workgroup 2**:**

  > Workgroup 2 is tasked to review, analyze, recommend, and prioritize options to offer a program to provide coverage under a state health or medical group insurance plan to non-state public employees of counties, cities, schools, area education agencies, and community colleges, and employees of nonprofit employers and small employers and to pool such employees with the state plan.

- **Workgroup Meetings and Focus**
  Workgroup 2 met on four occasions in the fall of 2009:

  - **September 29**
    Discussion with representatives of various public groups concerning their experiences in purchasing health insurance for their employees. Groups identified the following areas of concerns:
    - The ability to change insurance carriers to obtain access to affordable premiums.
    - Non-profit employers have such small staffs that one catastrophic claim can undermine the whole groups , leading to dramatically higher premiums at renewal.
  - **October 8**
    The Workgroup heard presentations by five health insurance industry representatives concerning insurance pooling and controlling health care cost increases. According to the presenters, the primary barrier to making pooling work is the size and wellness of the newly created group. Wellness programs

were identified as the key to lowering costs are realizing more affordable insurance premiums.

- **November 18**
  Discussion with representatives of entities that have formed insurance pools in Iowa about the challenges and lessons learned from pooling. Initial discussion of recommendations to the Commission.
- **November 24**
  Final discussion of recommendations to the Commission. (Telephonic Meeting)

The meetings were held at the Iowa Insurance Division (330 Maple St., Des Moines, Iowa). Notice of the meetings was provided to the the public on the Commission's web site (www.legis.state.ia.us/Current/Interim). In addition, a call in number was provided for telephonic meetings. A majority of workgroup members attended each of the meetings.

- **Background**

Connecticut Health Insurance Reform

In an effort to understand what other states are currently doing regarding opening up their state employee health insurance pools, the Workgroup examined Connecticut's *Connecticut Healthcare Partnership* and and its *SustiNet* legislation.

The ***Connecticut Healthcare Partnership*** *(HB6582)* would have allowed participation, on a voluntary basis, by municipalities, non-profit organizations (beginning July 1, 2010), and small employers (50 or fewer employees) (January 1, 2011) in the Connecticut state employee health plan. In addition, the *Partnership* legislation would would have converted Connecticut's state employee plan (excluding dental coverage) from a fully-insured plan to a self-insured plan. The conversion could only be made upon the agreement of the State Employees' Bargaining Agent Coalition and after canceling the existing fully insured state employee plan.

While the Connecticut Office of Fiscal Analysis estimated the Partnership could result in important savings to the State, there was also concern that introducing new participants to the existing Connecticut state pool had the potential to negatively effect the pool by altering the pool's composition. The Office of Fiscal Analysis was unable to offer an estimate of the size of the risk as there is no state that currently allows small businesses and non-profits to enter state employee pools.

There was significant concern that Connecticut's "rich" benefit package for state employees would be to expensive for the targeted groups (municipalities/non-profits and small employers) to purchase and only a small number of employers would join the pool, resulting in insignificant increases in the number of small firms offering coverage to their employees. Others were leery of having to renegotiate contracts with employees in municipalities that chose to join the new pool. These issues echo

what the Workgroup has identified as potential problems in opening up the Iowa state employee health insurance pool.

Ultimately, the *Connecticut Healthcare Partnership* was approved by the Connecticut legislature in 2009, but was vetoed by the Governor and the veto was sustained.

Sustinet is an ambitious health care reform bill introduced in the Connecticut legislature in January 2009. The *Sustinet* bill, which was drafted by the Universal Health Care Foundation of Connecticut was designed to move Connecticut onto a fast track for comprehensive health care reform with an emphasis on universal coverage. The bill's focus was on preparing the state for anticipated federal health care reform while advancing the state as close to universal coverage as possible. However, the deteriorating state and federal financial situation limited the state's ambitions, and ultimately, a scaled down version of SustiNet was enacted in July 2009, over Governor Rell's veto. (See Attachment 1 for additional information on Connecticut's reform efforts) The state is now moving cautiously towards its goal of achieving universal coverage prior to 2014.

- **Workgroup Materials**
  Information gathered by the Workgroup is available at the Workgroup's web page: www.legis.state.ia.us/Current/Interim

RECOMMENDATIONS

Recommendation 1: Adding New Groups to the Current State Pool.
The state employee pool currently provides a rich benefit package to a well defined group of persons, i.e. state employees. There are two primary concerns regarding opening the state pool to other groups (municipalities/non profits): 1) very few groups will enter due to the relatively high cost of the benefit plan, and 2) the effect of introducing new participants is unknown, but has the potential to increase the cost of insurance coverage to state employees.

> **Prior to adding new groups to the state employee pool, there needs to be measures developed which will protect the stability of the sate employee pool from both a cost and benefits perspective.**

To date, Iowa pooling has a mixed history. When pools have had poor results it appears a major factor is that groups exit from their pool at will.

> **Exit from pools, either the state pool if it is opened at some future date, or from other pools in Iowa, needs to be restricted by requiring that groups commit to a pool for a fixed number of years prior to being allowed to withdraw. Further research needs to be done to determine what the proper commitment (in years) should be before exit is allowed.**

Recommendation 2: Examine Potential New Directions for Increasing Coverage. Workgroup 2 has the most focused charge – developing options to include new groups in the state employee insurance pool – of the three workgroups. The Workgroup believes that having completed its initial look at state pooling there are still opportunities for it to contribute to the Commission's work and asks the Commission for future direction regarding the following:

1. Should the Workgroup reexamine the potential for adding new groups to the state employee pool once the direction of federal health care reform is clear? The goal would be to determine if new federal legislation influences how insurance pools are created or run and changes the climate for opening the state employee pool to the groups specified in SF 389.

2. Should the Workgroup reexamine the potential for adding additional groups to the state employee pool in light of recommendations coming out of Workgroups 1 and 3?

3. The Workgroup has determined that small employers have a strong desire to be treated like large employers when purchasing insurance for their employees. The Workgroup believes that further research should be done to identify opportunities for small employers to be able to purchase insurance in the same manner as larger employers. Specifically, the Workgroup asks for direction from the Commission as to whether it should investigate opportunities to alter the manner in which small employers purchase health insurance.

ATTACHMENT 1
CONNECTICUT LEGISLATION OF INTEREST

Summary Prepared for Workgroup II

October 28, 2009

Background
There are two pieces of Connecticut legislation of potential interest to Workgroup II:

- ***The Connecticut Healthcare Partnership*** (HB 6582)

- ***SustiNet*** (HB 6600)

Both bills were passed during the 2009 Connecticut legislative session, and were vetoed by Gov. Jodi Rell (R). Rell's veto of HB 6582 was sustained, however, she was overridden as to HB 6600, and the SustiNet Plan entered into law in July 2009.

The following is a brief analysis of the two bills.

✦ THE CONNECTICUT HEALTHCARE PARTNERSHIP (HB 6582)

This bill would have allowed participation, on a voluntary basis, by **municipalities**, **non-profit organizations** (beginning July 1, 2010), and **small employers** (50 or fewer employees) (January 1, 2011) in the Connecticut state employee health plan as an additional health insurance option for non-state employers.

In addition, the bill would would have converted Connecticut's state employee plan (excluding dental coverage) from a **fully-insured** plan to a **self-insured** plan. The conversion could only be made upon the agreement of the *State Employees' Bargaining Agent Coalition* and after canceling the existing fully insured state employee plan.

Had this legislation been enacted it would have positioned Connecticut as the first state to allow small businesses to join a state plan at this scale.

KEY PROVISIONS

Voluntary Participation. Supporters suggested that by participating in the state employee pool, small businesses, municipalities, and non-profit organizations would reduce employee health care costs while improving employee benefit packages.

When the bill was first introduced in the 2008 session, the authors were interested in making participation mandatory to reduce adverse selection risk and to assure an adequate number of participants. The 2009 legislation made participation **entirely voluntary** (but with a two year minimum participation requirement), but added a *Cost Containment Committee* with authority to control participation so as to reduce risk.

Enrollment. Any employer group where the entirety of the employees would join the pool would be immediately accepted into the state pool. Any partial group (employer seeking coverage of less than the entire employee universe) would be actuarially reviewed for risk. If a partial group's participation would negatively impact the state employee pool, it could be denied entry to the pool. The goal in requiring actuarial review was to protect the existing state employee pool by preventing an eligible employer form shifting a disproportionate share of its medical risk to the state.

Risk to State Employee Pool
Introducing new participants to the existing state pool has the potential to negatively effect the state pool by altering the pool's composition. The Connecticut Office of Fiscal Analysis was unable to offer an

estimate of what the monetary amount of that risk might be as there is no state that currently allows small businesses and non-profits to enter state employee pools.

COSTS

Participant and Other Costs. The new non-state employers would have been required to pay the same premiums as the state at the same coverage level, with the caveat that new groups could have their rates adjusted to reflect group characteristics. New employers could require employee premium contributions consistent with existing collective bargaining agreements.

State Costs. Connecticut would lose revenue from a insurance premium tax collected from municipalities, non-profit organizations, and small employers who currently purchase private health insurance for their employees. The State Comptroller would have added three employees at a cost of $245K (first year estimate).

SAVINGS

The Connecticut Office of Fiscal Analysis estimated a one time saving to the state of $70 Million.[1] The state would also have saved about $20 million per year in a risk charge, which would have been reduced by a $10 million annual cost for stop loss insurance covering excess claims.

In addition, the state suggested that employees of small municipalities and small businesses might achieve savings due to participation in a pool with greater purchasing power, pooled risk and administrative economies of scale.

CONCERNS[2]

There was significant concern that the benefit package for state employees is quite "rich" and that the targeted groups (municipalities/non-profits and small employers) would find the premiums too high and would not participate in significant numbers. Others were leery of having to renegotiate contracts with employees in municipalities that chose to join the new pool.

ADDITIONAL RESOURCES

Statute Text
http://cga.ct.gov/2009/ACT/PA/2009PA-00147-R00HB-06582-PA.htm

✦ **SustiNet PLAN (HB 6600)**

The original, ambitious SustiNet bill, drafted by the Universal Health Care Foundation of Connecticut and introduced in January 2009, was designed to move Connecticut onto a fast track for comprehensive health care reform with an emphasis on universal coverage. The bill's focus was on preparing the state for anticipated federal health care reform while advancing the state as close to universal coverage as

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1 The estimated savings is a result of the moving from the fully insured plan to a self insured plan as there is a date certain from which no more premiums are paid to the insurer by the state and on the same date the pool assumes direct responsibility for member claims. The savings would come from the time lag of from 30 to 60 day in paying providers from the newly created pool. Connecticut was paying about $70 million per month in premium and assumed that half of the incurred claims would be paid during the first two months of pool operation. [See Fiscal Note: http://cga.ct.gov/2009/FN/2009HB-06582-R010995-FN.htm]

2 Information from correspondence and discussion with Cara Passaro, legislative aide to CT House speaker Christopher Donovan.

possible.[3] However, the deteriorating state and federal financial situation put a definite crimp[4] on the state's ambitions, and ultimately, a scaled down version of SustiNet was enacted in July 2009, over Gov. Rell's veto.[5]

The current version of the legislation lays out a process for creating a voluntary "self-insured health care delivery plan" in Connecticut with the following goals:

- Improve the health of state residents
- Improve the quality of health care and access to health care
- Provide health insurance coverage to state residents who would otherwise be uninsured
- Increase the health care insurance coverage options available to residents and employers
- Slow the short-term and long-term growth of per capita health care spending
- Implement reforms to the health care delivery system that will apply to all SustiNet Plan members [Subject to the limitation that any SustiNet health care delivery system reforms affecting to plan members who are state employees, retirees, and their dependents must be subject to applicable collective bargaining agreements].

Despite the reduced scope of the legislation, it remains an ambitious plan, as it is anticipated that the Sustinet Plan will cover almost all of the state's 3.5 million residents, including the state's estimated 350,000 uninsured persons.

Despite the level of detail in the plan regarding coverage and governance, no decisions have yet been made on how to fund SustiNet. The legislature will be required to find the necessary funding after it receives the Sustinet board's recommendations (see below)

IMPORTANT SUSTINET PLAN DESIGN CONSIDERATIONS

✓ The plan will **assist Connecticut residents** who are uninsured or underinsured, are sole proprietors or self-employed, own small businesses, are municipal employees or are employed by non-profit entities.

✓ The SustiNet Plan offers the possibility of uniting the state employee plan, HUSKY[6] and SAGA (CT State Medical Assistance benefit).

✓ SustiNet uses the **existing public sector** to facilitate change in the health care system, without mandating changes in private behavior.

✓ Create a **public investment** in slowing health care cost growth and improving population health status.

✓ SustiNet does not create an insurance mandate.

KEY PROVISIONS

SustiNet Enrollment Groups.

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[3] There are several good sources of information on the "original" SustiNet Plan including: www.ct.gov/oha/lib/oha/Dorn_SustiNet_09_16_09.revised.ppt

[4] The legislation is 18 to 24 months behind the timeline envisioned by the original drafters.

[5] Full implementation of the SustiNet agenda has an estimated $950 million to $1 Billion cost to the Connecticut state treasury.

[6] HUSKY (*Healthcare for Uninsured Kids and Youth*) is Connecticut's version of Iowa's HAWK-i program.

- Non-state Public Employers
- State Employees, Retirees and Dependents
- Nonprofits Entities
- Small Employers[7]
- HUSKY PLAN Part A and B Beneficiaries to 300% of the federal poverty level (to the extent permitted by federal law)
- Medicaid and State administered general assistance programs
- Persons Not Offered Employee Sponsored Insurance (ESI)
- Persons Offered Unaffordable or Inadequate ESI – state residents with incomes up to 400% of the federal poverty level.

The Uninsured. The legislation provides that all state residents with incomes below 300% of the federal poverty level will be eligible to enroll in HUSKY A or B after July 1, 2012.

SustiNet Health Partnership Board.[8]
The legislation establishes a nine member board of directors whose broad charge is to 1) increase access to health care, 2) improve health care quality and outcomes, and 3) provide effective health care cost control. The legislation specifies that the SustiNet board is a voluntary organization and not a Connecticut department, institution, or agency. The Board does not receive any state appropriations.

The Board is required to make recommendations to the legislature, by January 1, 2011, on the design and implementation of the SustiNet Plan. The board's recommendations must address the following:

- The establishment of a public authority or other entity with the power to:
  - ✓ Contract with insurers and health care providers
  - ✓ Develop health care infrastructure ("medical homes")
  - ✓ Set reimbursement rates
  - ✓ Create advisory committees
  - ✓ Encourage the use of health information technology

- A phased-in offering of the SustiNet Plan to:
  - ✓ State employees and retirees – July 1, 2012
  - ✓ HUSKY A and B beneficiaries
  - ✓ Persons with employer sponsored insurance (ESI) or unaffordable ESI – July 1, 2012
  - ✓ Small and large employers – July 1, 2012

- Development of a model SustiNet benefits package

- Public outreach and methods of identifying uninsured citizens.

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[7] **Small Employers.** The SustiNet Legislation defines **small employer** as "a person, firm, corporation, limited liability company, partnership, or association actively engaged in business or self-employed for at least three consecutive months, which, on at least 50% of its working days during the preceding twelve months, employed up to 50 people, the majority of whom worked in the state."

[8] Board composition is set by statute and includes the state comptroller and the state health care advocate (board chairpersons); representatives from the provider community, the insurance industry, and organized labor; and persons with professional expertise in: a) health economics/policy; b) health information technology; and c) actuarial science. Additional information is available on the board's web site at www.ct.gov/oha/cwp/view.asp?a=3784&Q=446094&PM=1

In addition, the SustiNet Board must establish committees to address and make recommendations to the legislature regarding **health information technology**, **medical homes**, **clinical care and safety guidelines**, and **preventive care and improved health outcomes**.

Prevention Task Forces. Finally, the bill creates board task forces addressing obesity, tobacco usage, and the health care workforce.

Independent Information Clearinghouse. The bill also establishes an independent information clearinghouse to provide employers, consumers, and the general public with information about SustiNet and private health care plans.

SustiNet Benefits Package
The benefits package was designed to be comprehensive with an eye to mimicking what large Connecticut employers currently offer.

The SustiNet benefits package will require **out-of-pocket cost-sharing limits** and **provider network rules**, all subject to same coverage mandates currently imposed on small group health insurance sold in the state.

Specific benefits will include, but not be limited to:

- Medical home services
- Inpatient and outpatient hospital care
- Generic and name-brand prescription drugs
- Laboratory and x-ray services
- Durable medical equipment
- Speech, physical, and occupational therapy
- Home health care
- Vision care
- Family planning
- Emergency transportation
- Hospice
- Prosthetics
- Podiatry
- Short-term rehabilitation
- Identification and treatment of developmental delays from birth through age three
- Evidence-based wellness programs

Subsidies
The SustiNet Board will study the feasibility of subsidizing premiums for those earning between 300 and 400% of the the FPL. People in this income bracket would pay for premium on a sliding scale basis.

Cost Sharing
Individuals and families will be subject to a **deductible** that excludes drugs and preventive care (defined as, but not limited to well-child visits, well-baby care, prenatal care, annual physicals, immunizations and screenings).

Copayments will be applied to prescription drugs and to office visits for other than preventive care.

Other Included Coverage
Mental and behavioral health, including tobacco cessation, substance abuse treatment, and obesity prevention and treatment (these services require parity with coverage for physical health services). Enrollees will also have **dental coverage** comparable to that provided by large employers in the Northeast.

SustiNet Funding
This is an area that appears to be in flux. Currently, the SustiNet Board is charged with identifying all potential funding sources.

ATTACHMENT 1

COSTS[9]

Expanded Public Programs. By extending enrollment in HUSKY A or B to 300% of the FPL, the state anticipates an annual increase in state costs of at least $530 million. The state will pursue all possible federal reimbursements,however the eligibility changes to HUSKY are outside current federal eligibility standards. Without federal reform the state will absorb this entire cost.

State Agencies. The legislation will impose some additional administrative costs to the departments of Public Health, Revenue Services, Labor, Insurance, and the Office of Health Care Advocate.

Task Forces. The three task forces (obesity, tobacco use, and shortages in medical personnel) will impose minimal administrative costs to state agencies.

POTENTIAL SAVINGS
According to the legislation authors, the Universal Health Care Foundation of Connecticut, state residents and businesses can anticipate savings of $1.7 billion by 2014, if SustiNet is fully implemented and successful in attracting sufficient enrollment. According to the Foundation, Connecticut residents would save an estimated $875 per person on premiums and out of pocket expenses.

ADDITIONAL RESOURCES

Statute Text
http://cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=6600&which_year=2009

SustiNet Board Home Page
http://www.ct.gov/oha/cwp/view.asp?a=3784&Q=446094&PM=1
Currently, the Board is administered by the Office of the Healthcare Advocate, and is just getting operational, so the site isn't too fleshed out.

Universal Health Care Foundation of Connecticut
The foundation has a number of SustiNet publications available at www.universalhealthct.org

Original SustiNet Proposal
Stanley Dorn of the Urban Institute is the lead consultant on the SustiNet Plan. His original SustiNet proposal is available at http://74.125.95.132/search?q=cache:1eTdfhlmiPMJ:www.healthcare4every1.org/sustinetproposal+sustinet+stan+dorn&cd=2&hl=en&ct=clnk&gl=us&client=safari

KEY CT PLAYERS

Speaker Christopher Donovan
Rep. Betsy Ritter, Co-Chair of the Public Health Committee
Universal Health Care Foundation of CT
CT SEIU State Council
AFSCME Council 4

[9] See CT Office of Fiscal Analysis Fiscal Note available at http://cga.ct.gov/2009/FN/2009HB-06600-R010920-FN.htm

WORKGROUP 3 ADMINISTRATION OF HEALTH CARE REFORM IN IOWA
QUARTERLY PROGRESS REPORT

- **Members**
  Mr. Ted Williams (Chair)
  Mr. Mike Abbott
  Ms. Jennifer Browne
  Ms. Joan Jaimes
  Mr. Tom Newton, Director, Iowa Department of Public Health (Ex-Officio). Ms. Lynh Patterson attended the meetings as Mr. Newton's alternate.

- **Workgroup Web Page**
  http://www.legis.state.ia.us/Current/Interim

- **Charge**

At the Commission's meeting on September 9, 2009, Commission Chair David Carlyle presented the following charge to Workgroup 3**:**

> Workgroup 3 is tasked to review, analyze, recommend, and prioritize options related to the administration of health care reform in Iowa and creation of an affordable, accessible, seamless health care coverage system for all Iowans, by doing, including but not limited to, the following:
>
> A. Presenting options for the coordination of a children's health care network in the state that provides health care coverage to all children without such coverage; utilizes, modifies, and enhances existing public programs; maximizes the ability of the state to obtain federal funding and reimbursement for such programs; and provides access to private, affordable health care coverage for children who are not otherwise eligible for health care coverage through public programs.
>
> B. Presenting options for children, adults, and families to transition seamlessly among public and private health care coverage options.
>
> C. Presenting options to develop a long-term strategy to provide access to affordable health care coverage to the uninsured in Iowa, particularly adults, and development of a structure to implement that strategy including consideration of whether to utilize an existing government agency or newly covered entity.

During Workgroup 3's initial meeting on October 15, 2009, Chairperson Ted Williams suggested to the Workgroup that it focus its initial activities between October and December 2009 on answering the following question:

> 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?

The members agreed that given the current uncertainty surrounding federal health care reform, this was an appropriate initial charge.

- **Workgroup Meetings and Focus**
  Workgroup 3 met on three occasions in the fall of 2009:

  - **October 15**
    Discussion of the fundamentals of health insurance exchanges.
  - **November 11**
    Iowa Insurance Commissioner Susan Voss provided the Workgroup with information on opportunities for an Iowa health insurance exchange.

    Iowa Medicaid Director Jennifer Vermeer, Susan Voss and Dr. Bery Engebretsen (Iowa Nebraska Primary Care Association) discussed opportunities for creating a more seamless health care system for children, families, and adults in Iowa.
  - **November 20**
    Focused discussion of recommendations to the Commission.

With the exception of the November 11th meeting which was held at the Des Moines headquarters of the American Enterprise Group, the Workgroup's meetings were held at the Iowa Capitol. Notice of the meetings was provided to the the public on the Commission's web site (www.legis.state.ia.us/Current/Interim). In addition, a call in number was provided for meetings. A majority of workgroup members attended each of the meetings.

- **Workgroup Materials**
  Information gathered by the Workgroup is available at the Workgroup's web page: www.legis.state.ia.us/Current/Interim

RECOMMENDATIONS

Recommendation 1.
Iowa needs to move towards a more seamless system for Iowans moving from public health care to private health care coverage and for moving between public health insurance programs.

Specific options to assist in the creation of a more seamless system include:

- The Commission should work with the Department of Human Services to examine current and past recommendations to improve transitions between the Medicaid and hawk-i programs and to prioritize those recommendations which have not yet been put into effect.

- **Iowa needs a common portal for public program eligibility determinations.** To the extent legally possible, the state should use common definitions of income for determination of public program eligibility. While Department of Human Services representatives indicated that the health care reform bills in Congress include provisions for common eligibility common standards to promote seamless transitions, the Department needs to act now to make the process more seamless prior to 2014.

Recommendation 2.
Iowa needs to invest in the technology necessary to power a more seamless system for Iowans moving from public health care to private health care coverage and for moving between public health insurance programs.

- Iowa needs to aggressively seek opportunities to leverage federal funds available for Department of Human Services technology enhancements.

- Iowa state government needs to determine if it has adequate staffing levels to maintain a seamless system, and to the extent possible, add staff where necessary to promote seamlessness.

Recommendation 3.
Role of Safety Net Providers: **The Workgroup recommends information be readily available to Iowans that provides details about the health care services provided by the safety net providers, specifically:**

- The population served by safety net providers
- Where safety net providers located in Iowa, and
- What services safety net providers offer

Recommendation 4.
Creditable Coverage. The Workgroup recommends that the Iowa Insurance Division and the Insurance Commissioner pursue all statutory options to improve seamlessness through increasing opportunities for "creditable coverage" in Iowa.

Recommendation 5.
Iowa should begin the process of designing an Iowa Exchange.

The following issues need to be examined in designing an Iowa Exchange:

- **What functions should an exchange include?** If the exchange includes involvement in insurance benefit design, the following benefit components should be considered for inclusion:
  - ✓ A medical home model
  - ✓ A focus on prevention
  - ✓ Provisions for chronic care management.

Even in the absence of an Iowa Exchange, the above functions are important to adequate insurance benefit design,and should be considered by Workgroups 1 and 2 as they pursue their respective charges.

- **Is the optimum exchange model one that is light, medium or heavy?** The Workgroup believes that federal reform will, in all likelihood, determine the form that exchanges will take. However, to the extent the state has the opportunity to do so, Iowa should determine what model of exchange will produce the best opportunities for promoting affordable coverage given the state's demography and economy.

- **Who should be included in an Iowa exchange?** Should it include the individual and small group markets and public plans. The Workgroup recommends that an Iowa exchange include public and private sector participation**.**

- **Should participation in an Iowa Exchange be voluntary?** The Workgroup believes that unless Iowa has an individual coverage mandate, guaranteed issue and adequate subsidies for purchase of coverage for persons not eligible for public coverage, an Iowa exchange should start as an information clearinghouse with a focus on promoting seamless transitions. The clearinghouse model should provide information for the general public on health care quality and cost. If Iowa moves to an individual mandate, guaranteed issue and coverage subsidies, there will be a need to revisit the complexity of an Iowa Exchange.

- **Who should operate an Iowa Exchange?** The Workgroup recommends that state government should facilitate the creation of the exchange and assume operational oversight responsibility.

Recommendation 6.
An Iowa exchange will need to provide quality data on providers and plans, and data to consumers and funders on the cost of medical care. It is currently difficult to obtain data on provider pricing and Iowa should consider expanding opportunities to obtain greater transparency. Iowa will need to look at creating/encouraging common definitions for quality of care and health care prices.

Materials Filed With the Commission

- 12/4/2009 - David Lind's PowerPoint Presentation
- 12/2/2009 - Workgroup 1 Progress Report Draft from Chairperson David Carlyle
- 12/2/2009 - Workgroup 2 Progress Report Draft from Chairperson Marcia Nichols
- 12/2/2009 - Workgroup 3 progress report draft from Chairperson Ted Williams
- 11/23/2009 - Early Deliverables provided by Jennifer Vermeer
- 11/23/2009 - Long Summary provided by Jennifer Vermeer
- 11/23/2009 - Section-by-Section provided by Jennifer Vermeer
- 11/23/2009 - Short Summary provided by Jennifer Vermeer
- 11/23/2009 - Timeline provided by Jennifer Vermeer
- 11/17/2009 - Children's Health Fact Sheets, provided by Health Coordinator Anne Kinzel
- 11/17/2009 - Iowa Medicaid Fact Sheet, provided by Health Coordinator Anne Kinzel
- 10/20/2009 - A Template for Establishing and Administering Prescriber Support and Education Programs from Rep. Sharon Treat
- 10/20/2009 - Academic Detailing - At a Glance from Rep. Sharon Treat
- 10/20/2009 - Choices, Quality Affordable Health Care: A Work in Progress, A Window of Opportunity - Maine Center for Economic Policy
- 10/20/2009 - Employer Sponsored Insurance Coverage from Anne Kinzel
- 10/20/2009 - LD 1264 - 2009 Changes to Maine Dirigo Program - from Maine State Representative Sharon Treat
- 10/20/2009 - Maine State Representative Sharon Treat's Biography
- 10/20/2009 - Mission Summary of Workgroup 1 - Coverage of Adults
- 10/20/2009 - National Health Reform - Lessons from Maine - Maine Center for Economic Policy
- 10/20/2009 - Status Report from Workgroup III - Administration of Health Care Reform in Iowa
- 9/25/2009 - Census Bureau Estimates of Uninsured - Health Affairs Policy Journal, submitted by Commissioner Voss

- 9/9/2009 - Anne Kinzel Bio Statement and Resume
- 9/9/2009 - Devin Boerm Testimony
- 9/9/2009 - DHS Iowa e-Health Project - Health IT Extension Program-Regional Centers Cooperative Agreement
- 9/9/2009 - DHS Iowa e-Health Project - State HIE Cooperative Agreements
- 9/9/2009 - Health Reform in Iowa: Iowa Department of Public Health's Role - Revised
- 9/9/2009 - IDPH- Health Care Reform Council Priorities and Timelines
- 9/9/2009 - Legislative Health Care Coverage Commission Workgroups Duties
- 9/9/2009 - Meetings on Value in Healthcare by Concord Coalition
- 9/9/2009 - Overview of President's Health Reform Plan
- 9/9/2009 - The Check-Up - Update on Health Reform, August 2009 Issue by DHS
- 9/9/2009 - Update on DHS Projects #7 - Health Care Reform Implementation