WISCONSIN LEGISLATIVE COUNCIL

HEALTH CARE REFORM IMPLEMENTATION

Room 411 South
State Capitol

September 21, 2010
10:00 a.m. – 4:30 p.m.

[The following is a summary of the September 21, 2010 meeting of the Special Committee on Health Care Reform Implementation. The file copy of this summary has appended to it a copy of each document prepared for or submitted to the committee during the meeting. A digital recording of the meeting is available on our Web site at **http://www.legis.state.wi.us/lc.**]

Call to Order and Roll Call

Co-Chair Erpenbach called the committee to order. The roll was called and a quorum was present.

COMMITTEE MEMBERS PRESENT:	Sen. Jon Erpenbach and Rep. Jon Richards, Co-Chairs; Sen. Alberta Darling and Rep. Pat Strochota, Co-Vice-Chairs; Sen. Judy Robson; Reps. Marlin D. Schneider and Jennifer Shilling; and Public Members Wendy Arnone, Tim Bartholow, Ed Harding, Jeff Huebner, Robert Kraig, Joe Leean, David Newby, Candice Owley, Robert Palmer, William Petasnick, Robert Phillips, and Barbara Zabawa.
COMMITTEE MEMBERS EXCUSED:	Public Members Cheryl A. DeMars and David Riemer.
COUNCIL STAFF PRESENT:	Laura Rose, Deputy Director, and Heidi Frechette and Margit Kelley, Staff Attorneys.
APPEARANCES:	Bill Oemichen, President and CEO, Cooperative Network; David Stella, Secretary; Lisa Ellinger, Deputy Administrator, Division of Insurance Services; and Bill Kox, Director, Health Benefits and Insurance Plans Bureau; Department of Employee Trust Funds (ETF); Jon Kingsdale, Ph.D., Kingsdale and Associates, LLC., former Executive Director, Massachusetts Health Connector (via conference call); David Jackson, Director, Utah Health Exchange; Rachel Currans-Sheehan, Executive Assistant, and Craig Steele, Office of Health Care Reform Program Manager, Department of Health Services (DHS).

Approval of the Minutes of the Committee's August 19, 2010 Meeting

The minutes of the August 19, 2010 meeting were approved by unanimous consent.

Presentations by Invited Speakers

Bill Oemichen, President and CEO, Cooperative Network

In addition to the information presented in his written comments, which may be found at: http://www.legis.state.wi.us/lc/committees/study/2010/REFORM/index.html, Mr. Oemichen gave an overview of how health cooperatives operate and the important role they play in Wisconsin. He stated that the cooperatives are guided by seven principles and are responsive to members. He highlighted that there are currently 20 health care cooperatives that operate in the state, of which 19 are headquartered in Wisconsin and one in Minnesota. He discussed how Wisconsin law is unique in that it contains substantive insurance provisions in the cooperative law statutes while most states do not have cooperative laws that encompass health care. He emphasized that the state law governing cooperatives has been updated to allow them to function in light of federal law. He explained that while cooperatives have been in business for 30 years or more, they still face challenges. He gave the example of the difficulty dairy farmers had in accessing health insurance and how many of them have banded together to form a health care purchasing alliance so they all could be underwritten as one group.

In response to questions from committee members, Mr. Oemichen made the following points:

- Cooperatives are interested in being part of the health exchange, but an issue of concern is the requirement that the plan be open to everyone. For example, farmers have unique access issues so their cooperative focuses on their industry. These farmers are concerned that a health exchange would force them to be part of a larger cooperative with others who do not share their issues. This issue raises an interesting question for some cooperatives--should they stay out of the health exchange and forego federal subsidies or become part of the exchange and open up access to others outside their industry.

- There are 10 cooperative groups in the state including small employers, school districts, administrative employees, physicians, and other health care workers along with five additional groups in the development stage.

David Stella, Secretary; Lisa Ellinger, Deputy Administrator, Division of Insurance Services; and Bill Kox, Director, Health Benefits and Insurance Plans Bureau; Department of Employee Trust Funds

Representatives from ETF gave an overview of department-described health insurance plans (PP), scope, governance structure, and administration. A detailed account of the information they presented may be found at http://www.legis.state.wi.us/lc/committees/study/2010/REFORM/index.html.

In response to questions from the committee, the ETF representatives made the following points:

- ETF is a purchasing pool not exchange, because the agency focuses on one area of employee benefits, and does not work with Medicaid, individual insurance, or grant funding.

- As currently configured, ETF could not run an exchange. While ETF has expertise in areas such as the risk adjustment process, pharmaceutical formulary, and plan negotiation and are happy to share their expertise, they currently have six employees and are concerned that if they were tasked with running the health exchange, it would take away staff, attention, and resources from their current focus.

- ETF works well with the bordering state of Minnesota.

- Each insurance plan addresses wellness programs differently; addition of such programs will be part of the mission going forward.

- Catastrophic plans with health savings accounts have not been offered as part of ETF because of adverse selection potential and high costs.

- ETF would be willing to advise an exchange, but the agency is funded through various trust funds so it cannot use this funding for purposes other than providing and administering benefits.

- ETF's plans, tiering system, and competitive model could have had an effect on lowering premiums and may be informative on how an exchange could have a similar effect in the state.

- Choice is key in Dane County where ETF has a lot of market share. There is value in people being able to choose their health care plan; choice model works because it leads to low-cost and high quality plans.

Jon Kingsdale, Ph.D., Kingsdale and Associates, LLC., former Executive Director, Massachusetts Health Connector (via conference call)

In addition to discussing the information in his PowerPoint presentation, which can be found at http://www.legis.state.wi.us/lc/committees/study/2010/REFORM/index.html, Dr. Kingsdale made the following additional points:

- Dr. Kingsdale believes an independent authority is the best choice for governing the exchange. However, a 10-member board, like that used in Massachusetts, is possibly too large. In regard to the makeup of the board, there are two models: (1) appointment by expertise, in California; or (2) appointment by interest group and expertise, as in Massachusetts.

- It is important to protect the exchange against adverse selection. The California legislation has an example of one way to prevent adverse selection.

- If competition for price and quality care is desired, there needs to be fair allocation of the sick among the health plans, or some risk adjustment.

- It is important to strive for long-term relationships with health insurance carriers.

In his closing remarks, Dr. Kingsdale shared some of the lessons learned in setting up the Massachusetts exchange. He stressed the importance of communication and the ability to show results.

He compared setting up an exchange to running a campaign or an entrepreneurial activity. He indicated that Massachusetts launched a smaller exchange as a pilot, shut it down and re-opened it. He stressed the importance of marketing the exchange and partnering and outsourcing for certain functions.

In response to questions from the committee, Dr. Kingsdale made the following points:

- Cost is one issue of health care reform. He estimated that it took $350 million from the state for all health reform activities, which included the cost of administering the connector itself. This is about 3% of the premiums collected. However, the trend has been very good for Commonwealth Care at below 5% increase for premiums, which is less than half of the rates outside the exchange. In the subsidized exchange, the state can encourage purchase of higher quality plans. For innovation, they offer a shelf-space where smaller network plans can get in, and encourage different plan benefits.

- Proponents of the Massachusetts exchange fell into the routine of talking about it as universal health care. The focus was on providing general access, not directly working on reducing costs. Health care cost containment is extremely difficult. But there has been some modest positive benefit on cost. He does not see exchanges as significantly cutting the rate of increase for health insurance premiums.

- There was no legal challenge to the health reform in Massachusetts.

- There is no data showing that Massachusetts became a magnet for the uninsured with the implementation of health care reform.

David Jackson, Director, Utah Health Exchange

In addition to presenting information in a PowerPoint presentation, which can be found at: http://www.legis.state.wi.us/lc/committees/study/2010/REFORM/index.html, Mr. Jackson described the Utah Health Exchange as offering a private sector health care solution facilitated by the state. He stated that Utah has a population of 1.3 million, composed of a highly literate and highly educated workforce who are technologically savvy and rugged individualists.

In response to questions, Mr. Jackson made the following statements:

- Utah will likely seek waivers for those elements of the state exchange that may conflict with the federal health care reform law.

- Initially the legislation passed unanimously. Since then, legislation has supermajority support by both parties. There is motivation to participate because people prefer the Utah solution to a federal solution.

- The exchange has not been up and running long enough to have an impact on insurance rates and costs, but they do anticipate improvement in costs because of the perception by consumers that they are spending their own money.

- They are unable to do models and make projections on any impact the exchange has had on uninsured rates and costs because of low start-up funds, but he believes the exchange will

likely overtake the traditional market. Employers really want to be in the exchange, because then they can get out of the insurance business.

- Future goals are for a robust wellness system, and providing information on plan quality.

- The Utah exchange uses an eight-question health risk assessment as part of enrollment that carriers underwrite, so it is susceptible to the same problems as insurance outside the exchange when it comes to individuals answering the questions honestly.

Rachel Currans-Sheehan, Executive Assistant, Department of Health Services, and Craig Steele, Project Manager, DHS Office of Health Care Reform

Ms. Currans-Sheehan was accompanied by Craig Steele, Project Manager from the Office of Health Care Reform (OHCR). She discussed the exchange planning grant and the request for comments from the Department of Health and Human Services regarding the major factors states should consider in designing exchange. DHS will be submitting comments on behalf of OHCR.

She stated that Wisconsin will save an estimated $850 million in general program revenue (GPR) once the exchange is up and running in 2014 through 2019 and approximately $500 million to $1 billion will come to Wisconsin residents in the form of tax credits. She believes that Wisconsin has a strategic advantage because of its modern IT infrastructure and the fact that DHS staff have been working on exchange design for the past two years at the request of the Governor.

According to Ms. Currans-Sheehan, DHS used the following five guiding principles in designing an exchange:

(1) Keep it simple.

(2) Make it transformative.

(3) Build off regional strengths.

(4) Focus on customer service.

(5) Coordinate with existing initiatives.

According to Mr. Steele, DHS has received a $1 million planning grant from the federal government and will devote $400,000 to two research initiatives, which will: (1) provide a comprehensive survey of the insurance market in Wisconsin to determine questions such as whether there should be one or two exchanges and if the exchange should be the only market for purchasing insurance; and (2) assist in developing a predictive model to understand how an exchange would work in the state. Another grant will come out next year and will be for implementation; therefore, the state will have to develop an estimate to support the implementation of exchange.

Ms. Currans-Sheehan also stated that a quasi-public authority is a good governance model for the exchange but it would be important to ensure the board was non-political and kept small. She suggested that the committee look at board membership and consider whether or not insurers would be part of the board because of their expertise or if that would be a conflict of interest. She also recommended that the committee consider where the actual exchange would be housed. DHS is working on a functional model

and plans to produce options papers and have a predictive model based on survey results before the end of the year.

In response to questions, Ms. Currans-Sheehan made the following statements:

- In response to federal health reform deadlines, DHS is moving forward on state implementation to secure federal funds by meeting with stakeholders and commissioning the survey on insurance market in the state.

- DHS is taking into account concerns of insurers in looking at the health exchange design and is considering regional plans, not just three to four plans for the whole state.

Discussion of Committee Assignment

Ms. Rose and Ms. Frechette described Memo No. 1, *Health Benefits Exchanges in Selected States and Under Federal Health Care Reform.*

The committee discussed the need for guiding principles and input on the structure/governance of a health exchange. The Co-Chairs requested that committee members send their suggestions on both topics to the Legislative Council staff by October 5, 2010, so the staff can assemble the comments and draft an options paper for the October 21, 2010 meeting. At the October 21 meeting, the committee will do the following:

- Decide if the state should run its own health exchange or allow the federal government to run it.

- Agree on guiding principles in developing an exchange.

- Discuss and develop ideas for governance structure of a state health exchange.

Other Business

Earlier in the meeting, Mr. Newby requested information from staff on how the federal law affects self-insured plans and Taft-Hartley plans. There was no other business brought before the committee.

Plans for Future Meetings

The next meeting will be held on October 21, 2010 in Madison.

Adjournment

The meeting was adjourned at 4:30 p.m.

HJF:jal