# WISCONSIN LEGISLATIVE COUNCIL

## HEALTH CARE REFORM IMPLEMENTATION

Room 411 South
State Capitol

November 9, 2010
10:00 a.m. – 3:17 p.m.

[The following is a summary of the November 9, 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.**]

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### Call to Order and Roll Call

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

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| 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, Cheryl A. DeMars, Jeff Huebner, Robert Kraig, Joe Leean, David Newby, Candice Owley, Robert Palmer, William Petasnick, Robert Phillips, David Riemer, and Barbara Zabawa. |
| COMMITTEE MEMBERS EXCUSED: | Public Members Ed Harding and Tim Bartholow. |
| COUNCIL STAFF PRESENT: | Laura Rose, Deputy Director, Heidi Frechette and Margit Kelley, Staff Attorneys, and Lael Grigg, Staff Intern. |

### Approval of the Minutes of the Committee's September 21, 2010 Meeting

*Motion was made by Senator Robson, seconded by Mr. Newby, to approve the minutes of the September 21, 2010 meeting; the minutes were approved by unanimous consent.*

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## Description of Materials Distributed

Ms. Frechette and Ms. Kelley described Memo No. 2, *Selected Issues Relating to Application of Federal Health Care Reform Law,* dated October 15, 2010.

Ms. Frechette and Ms. Rose described Memo No. 3, *Guiding Principles for Committee Discussion,* dated October 15, 2010.

## Discussion of Committee Assignment

### *Discussion of Guiding Principles and Motion*

The committee debated the scope of the work that the committee should undertake given the changes in the majority leadership for Wisconsin's Legislature and Governor on January 3, 2011. After discussion, the Co-Chairs directed the committee to consider guiding principles that could be utilized if the state develops its own health exchange, and to consider general recommendations for the governing body of such an exchange.

Senator Darling stated that Governor-Elect Walker has a strong interest in addressing health care costs and access and maintaining Wisconsin's high-quality health care delivery system, and is not interested in having a federally run health care system for Wisconsin.

Mr. Riemer noted that Governor-Elect Walker has stated that he would prefer to have a private entity run Wisconsin's health exchange. Mr. Riemer suggested that a quasi-governmental authority, like Wisconsin's Health Insurance Risk-Sharing Plan (HIRSP) Authority, seems to be a good model that would fit the Governor-Elect's preference.

Co-Chair Erpenbach asked what the principle of improving health care quality means to the committee members.

Mr. Petasnick said that he sees three guiding principles when looking at health care reform. First, the principle of the market is fundamental; a pluralistic market is necessary in health insurance options, but he is concerned about the erosion of the private insurance market. Second, as a principle, the governing structure of a health exchange should be independent, not embedded in government, and should be somewhat insulated from the political process. Third, health care must revolve, as a principle, around the concept of value, which relates to costs, quality, and access.

In response to a question, Ms. DeMars explained that the eValue8 health plan assessment tool was developed by purchasers to develop common requests for information. It incorporates current tools like Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Healthcare Effectiveness Data and Information Set (HEDIS), but instead of just measuring performance, it provides aspirational goals to provide a roadmap for plans to use with providers to provide a plan for improvement. It measures not just performance, but also management of population health. It would establish some standards that could be used as criteria for admission to the health exchange. As an example, in addition to the things that are typically evaluated by HEDIS and CAHPS, the requests for information might ask: are plans measuring avoidable admissions to hospitals? And if they are, how are plans working with hospitals and physicians to prevent avoidable admissions?

Co-Chair Richards asked if the committee could agree that, in order to participate in the health exchange, a health plan must report its quality measures to a third party that makes its findings available to the public, without specifying which assessment tool should be used.

Mr. Riemer commented that it seems that quality standards are constantly evolving, so it would seem that the health exchange's board should have the authority to modify whatever particular measures are used. He stated that there should be a method for actively reporting a health plan's standards to a board, but the measurement system itself should be flexible.

Ms. DeMars clarified that eValue8 is only one example of a quality assessment tool, and that what is important is that the information be publicly available, and that it is relevant to consumers.

Ms. Zabawa commented that there are three checks that she finds helpful, as a framework, in evaluating quality in health care plans and delivery: structure, process, and outcome.

Senator Robson stated that she would like to emphasize cost-sensitivity, or cost awareness, by patients. If a patient is more sensitive to the cost, the patient may challenge the need for certain tests or treatment, which could help build in cost-effectiveness.

Co-Chair Richards commented that the committee seemed to agree that some level of individual patient responsibility is necessarily part of quality.

A number of committee members commented on the importance of focusing on payment for performance, and outcomes of care, rather than payment for quantity of services. Other members commented that performance-based payment is a worthwhile goal, and Wisconsin is working towards that, but that in practical terms it would be difficult for the committee to direct, due to the existing contractual agreements between plans and providers for payment of services.

Mr. Riemer said that when the committee talks about payment for services, he assumes it is for a plan's payment for services, because it is not the health exchange that would pay. He hopes that the committee would recommend that for a plan to participate in the exchange, it be required to disclose its payment structure and any quality of care measurements and improvement programs. He prefers that plans be required to have quality improvement programs in order to participate in the health exchange, but would at least like to see that plans be required to disclose their systems for improving wellness and evaluating performance.

Mr. Newby agreed that at a minimum the health exchange should require that plans report to a third party. He would like to see the requirements go further, and for the health exchange to reward behaviors, and not just provide information.

Ms. Arnone commented that when discussing quality, the discussion should include efficiency. Ms. Arnone noted that the topics of quality and efficient use of resources are coupled, and should be part of the same discussion. Otherwise it would be possible to have an inefficient use of resources, but still have the same quality outcome as in a health care incident where resources were used efficiently.

In response to a question, Mr. Leean explained that he would see wellness programs as part of a cost-containment principle, more so than as part of a quality principle. He would like to see if there are ways to provide incentives to providers who spend time with patients to talk about their wellness habits,

and to provide incentives if providers have a statistical reduction in their population for chronic problems such as asthma, obesity, smoking, or diabetes.

Senator Darling commented that she is interested in putting forward concepts that will have a consumer-driven model, with better costs, that maintains quality of care. She does not want to deter the positive reform efforts that are already in progress, such as the Wisconsin Health Information Organization (WHIO).

Mr. Petasnick said he does not want the committee to lose track of the idea of the health exchange as a connector, helping individuals who are not covered to find coverage.

Ms. DeMars suggested that a possible overarching guiding principle would be to continuously review quality measures. She noted that it would be useful for the consumer to have the health exchange provide information not just on general provider quality, but also information on individual doctor and hospital quality.

> *Mr. Petasnick moved that the committee recommend a framework for the guiding principles of the health exchange as follows: (1) maintain a pluralistic marketplace, for a robust private insurance market in the state; (2) create a governance for the health exchange that is independent and insulated from the political process, but is publicly accountable through measures such as being subject to the open records law, audits, and regular reporting to the Legislature; and (3) promote value and transparency within the health care system, with a focus on cost-efficiency, quality, access, and prevention.*
>
> *Mr. Leean seconded the motion, which was approved by unanimous consent.*

Dr. Huebner stated that the affordability aspect for patients should be included in the value principle.

***First Guiding Principle: Maintain a Pluralistic Marketplace***

Representative Strachota suggested that the general paragraph for principle no. 6, on page 7 of Memo No. 3, would be a good statement for the now-agreed-upon principle of a pluralistic marketplace.

The committee discussed whether rules that apply to plans that are in the health exchange will also apply to plans offered outside the exchange. The Co-Chairs directed there might be federal regulations that will address that question in more detail, and the committee would not need to make that determination.

Mr. Newby commented that he would not want the requirements to become a burden to a plan looking to join the health exchange.

Dr. Huebner suggested that in the principle for marketplace competition it be stated that the health exchange could facilitate not-for-profit plans.

Mr. Riemer and Mr. Kraig stated that they believe there will be one national non-profit plan that will be available for each state's exchange, which will be based on the federal health coverage model.

Co-Chair Richards suggested that the health exchange should foster innovation in products that are available, and should have the ability to respond to changes in the marketplace.

Ms. Zabawa suggested that in the paragraph from Memo No. 3, noted by Representative Strachota, for the principle of a pluralistic marketplace, that it be revised to be "accessible and attractive to private insurers and insureds."

The committee agreed that, for the principle of a pluralistic marketplace, the paragraph noted by Representative Strachota from Memo No. 3 be adopted with the insertion of "and insureds."

***Second Guiding Principle: Independent, Publicly Accountable Board***

The committee then discussed the second principle, regarding the creation of an independent but publicly accountable board, to govern the health exchange.

Representative Strachota suggested that the HIRSP letter that was enclosed with Memo No. 4 be disseminated as the committee's recommendation for the health exchange's governing board.

Mr. Kraig stated that the health exchange board should be publicly accountable and transparent.

Mr. Riemer suggested that the board of the health exchange should be smaller than the current HIRSP board of 13 members. The health exchange board should take advantage of the expertise available in other agencies, such as the Department of Health Services' (DHS) experience enrolling people in the Medicaid and BadgerCare programs.

The Co-Chairs directed the Legislative Council staff to prepare a bill draft for the creation of a HIRSP-like board that is independent but publicly accountable, for the committee's discussion at the next meeting.

***Third Guiding Principle: Value and Transparency***

The committee then discussed the third principle, regarding value and transparency, which include the principles of quality, access, prevention, and cost-effectiveness. Ms. Rose noted that the general points on this topic that were already discussed included gathering and reporting data, and creating incentives to improve health status.

Ms. DeMars asked the committee to remember that value should always include discussion of efficiency, since this is always relevant to consumers.

Dr. Phillips noted that there is a new health care transparency law that will be effective January 1, 2011, that was authored by Co-Chair Richards that includes quality measures. With that, he said, the state is uniquely positioned with some robust, valid, quality measures.

Co-Chair Richards responded that the list of requirements from the new state law could be made available to the committee. He noted a few reservations: there was not consensus around the law, and he has learned that there are some providers who do not participate in the program. But he suggested the committee could look at the statute if that would help to provide any more detail.

Dr. Phillips noted that WHIO was created by legislation, which means Wisconsin already has an entity in place that collects data. He stated that since there is a mechanism in place, providers should not have to duplicate that effort through a separate requirement to the health exchange.

Ms. Zabawa suggested that the committee direct the health exchange to collaborate or coordinate with existing quality measure tools, such as WHIO or eValue8, and the information could be collected and provided to the public.

***Fourth Guiding Principle: Patient-Centered, Coordinated Care***

Dr. Huebner stated that he would like to see a recommendation that all Wisconsinites should have a medical home that they can go to for all of their care, like a primary care provider, which statistically helps in preventive care and reducing costs. He noted that reliable primary care should be available for everyone.

Co-Chair Erpenbach suggested that a fourth principle could be added to the three suggested by Mr. Petasnick, to emphasize the importance of a medical home for every person.

Mr. Riemer stated that it would be appropriate to require plans to show whether or not they have a medical home policy. However, he noted it may not be practical to require that a plan offer a medical home plan in order to participate in the health exchange, as they are not offered by all plans.

Ms. Arnone noted that medical homes may be the most efficient way to access health care, but that this is a plan design issue. She informed the committee that not every provider is ready to be a medical home, nor will all consumers choose to utilize a medical home.

Mr. Palmer stated that some health care delivery organizations may be using the term "medical home" as a euphemism for how primary care is provided, particularly relating to high quality, continuity of primary care, and access to specialty care. He thought it could be problematic to require that a plan offer a medical home to participate in the health exchange.

Co-Chair Erpenbach stated that when he thinks of a medical home, he is thinking about a primary care provider that knows the patient, and knows the family, so perhaps this could be promoted.

Ms. Arnone noted that "medical home" is a very specific, defined term.

Senator Darling noted that there is a shortage of primary care doctors in the United States, so if the requirement is overly prescriptive, and requires a medical home, it could not be fulfilled.

Dr. Phillips pointed out that there is a separate Wisconsin Legislative Council study looking at the issue of health care access, and that for purposes of these principles, it would be adequate to note that access is a piece of the value consideration.

Senator Robson noted that health care includes both the provider and the patient, and that the patient needs to be included in the package.

Ms. Arnone stated that she would be concerned with how integrated, coordinated care for patients is defined, as this could mean different things in different plans, and consumers would not be able to tell the difference.

Dr. Phillips stated that he would agree with elevating access for patients to a fourth guiding principle.

Co-Chair Erpenbach suggested that the fourth guiding principle be the encouragement of patient-centered, coordinated care, which would cover everything, including medical homes. The prevention principle would fall under coordinated care.

Mr. Leean stated that transparency should include informing the consumer about how care is coordinated.

Mr. Riemer asked if there is anything the health exchange can do to address the cost of care. He suggested that the Department of Employee Trust Funds (ETF) is a good example of cost management, where ETF has had good success in Dane County. He suggested that a critical mass is needed to effect change in costs. If only 10% of the population is in the health exchange, that would not be enough participants to push changes in the market and lower costs.

Mr. Palmer noted that Dane County is unusual, because it has four large providers, that are each provider-owned. He also noted that the federal law does not address costs, it addresses health care reform.

Ms. Owley noted that the health exchange is not going to be able to mandate people in.

Ms. Arnone stated that the size of the pooling itself would not drive down health care costs; the biggest cost-driver is in health care delivery. According to Ms. Arnone, current successful efforts to bring down costs have been in incentive programs, like cash rewards for smoking cessation. She stated that premiums will come down when health care is accessed more efficiently.

Mr. Kraig agreed that a large pool of participants itself would not lower costs, but stated that it could be a leverage tool. The federal law does include some cost reform measures, though it is questionable if they work. Cost is already out of bounds; small businesses cannot afford it, and soon government and larger employers would not be able to afford it.

Ms. DeMars noted that if the health exchange lowers the cost of premiums, it will just raise premium costs for plans offered outside the health exchange, so the committee should be looking at lowering the cost of health care, not just lowering the cost of premiums in the health exchange.

Mr. Leean asked what suggestions can be made to lower actual costs, beyond lowering costs though purchasing power, from the market share.

Mr. Riemer noted that in Dane County the health care delivery costs themselves are lower, not just the premiums. He is not suggesting price controls. Additionally, he stated, if government employees were put into the health exchange pool, it would increase the size of the pool.

Dr. Huebner stated that if one principle for the health exchange is to be as pluralistic as possible, that means that the pool itself would not work to lower the costs. He suggested looking at innovative models that have been proposed to see if they would work in Wisconsin.

Mr. Kraig noted that in comparing the ETF pool between Madison and Milwaukee, it seems that at some point between 10% and 20%, a market share is reached that affects costs.

Ms. Zabawa stated that the health exchange cannot be the panacea for reducing all costs, but the health exchange can be a conduit for providing information, and information is powerful. She suggested that the committee can at least ask that the health exchange collect the information.

Co-Chair Erpenbach suggested that for transparency and cost, the guideline could be to pursue strategies that have been shown through research and evidence to reduce health care costs and increase quality, and the health exchange should provide incentives to consumers and providers to adopt those strategies. Co-Chair Erpenbach noted that the committee had general consensus on this guideline for the cost principle.

Mr. Palmer stated that he likes incentives, but the problem is funding.

Co-Chair Erpenbach noted that the committee had general consensus on the guideline for access, which focused on the patient-centered coordinated health care.

## Other Business

There was no other business brought before the committee.

## Plans for Future Meetings

The next meeting will be held on ***Monday, December 13, 2010, at 10:00 a.m., in Room 412 East, State Capitol, Madison***.

## Adjournment

The meeting was adjourned at 3:17 p.m.

MSK:jal