Wyoming Healthcare Commission Meeting Minutes
Jan. 26, 2004
Casper, Wyoming

Attendance: Commissioners George Bryce, Stacy Childs, M.D., Carol Jenkins, Paul Lang, Steve Mossbrook, Chris Muirhead, Dixie Roberts, and John Vandel; Ex-Officio Commissioners Deborah Fleming, PhD, and Ken Vines; Director, Diane Harrop, Executive Assistant Emily Genoff.

Meeting called to order, 8:12 a.m.
Chairman Muirhead introduced new Commission member Steve Mossbrook, who was appointed by the Governor after Robert Volz, M.D. resigned in December. Mr. Mossbrook lives and works in Riverton where he is CEO of Wyoming.com

Mr. Muirhead reviewed the Commission's December retreat in Douglas, where a work plan for the coming year gelled. Four committees were formed and Mr. Muirhead presented their Commission member appointees and focuses:

- Healthcare Access and Affordability chaired by Paul Lang, with Dr. Fleming and Mr. Vandel;
- Affordable Health Insurance and Cost Shifting Remedies, led by George Bryce, with Ms. Roberts and Mr. Vines;
- Disease Prevention, Management and Healthcare Information Technology, chaired by Carol Jenkins, with Dr. Childs and Mr. Mossbrook;
- Medical Malpractice Errors Compensation and Professional Licensing, chaired by Mr. Muirhead, with Mr. Bussart.

Chairman Muirhead noted additional appointments to the committees are planned and committee chairs are contacting potential non-commission contributors to their work. Preliminary research has been launched by committee chairs. They gathered recently in Casper to learn about Request For Proposal (RFP) bidding from a Department of Health consultant.

Motion to accept the new committee structure made by George Bryce, seconded by John Vandel. **Motion carried unanimously**.

The first speaker on the agenda was **Tom Gallagher, Director of Research and Planning (R&P), Wyoming Department of Employment**. Mr. Muirhead introduced Mr. Gallagher by noting that frequently the Commission is in need of additional information upon which policy can be based. Part of the day would be spent exploring the types of information needed to archive to keep policy makers informed in the long term regarding the state's healthcare delivery system.

Mr. Gallagher said that access to affordable health insurance, workforce shortages, aging population and cost shifting are four areas where the Department of Employment's (R&P) data collection and the Healthcare Commission's statutorily mandated areas of

research overlap. He noted that, for example, his office is studying nursing supply and demand issues already.

R&P conducts wage and occupational surveys, the state's employee benefit survey (used in the State Planning Grant (SPG) Task Force's research), and federal/state statistical gathering and research as tools in analyzing the state's workforce. One national research project is in the works that will improve the benefit survey. R&P is also involved in worker retention and turnover research (handouts available from Tom Gallagher, tgalla@state.wy.us, (307) 473-3801).

He noted Wyoming has a low-wage economy with disparity between what genders earn. Average earnings in Colorado are a third higher than in Wyoming, even though unemployment is higher there (explaining why Wyoming workers might leave the state for work). R&P is working with the Community College Commission and the Board of Nursing. Episodic research R&P has done has addressed retention of teachers and wage/gender equity. Communities recruit families, not individuals, Mr. Gallagher noted. If we want to look at a particular set of occupations – such as physicians, nurses, or allied health professionals – and their recruitment and retention, we need to put that in the context of spouses looking for work when families relocate.

The Department of Employment will be gaining access to worker's compensation information. R&P conducts an occupational health and safety survey reporting workplace injury and illness but there isn't an inventory of standard reports related to the healthcare system. There is no systematic approach to comparing demographics to specific areas of need. We know the demographics of workers who do not have access to healthcare, but we haven't done a lot of research on it. We've built a framework. That framework could be capitalized upon. We have the capacity to link worker's compensation cases to subsequent earnings. We can probably create a healthy research project on the issue of worker's comp. When we look at coal bed methane we can see a number of people working in that industry with no experience in mining, and therefore are prime candidates for workforce injury. Worker's comp doesn't have a research agenda. We also operate the fatal occupational injuries and illnesses census, obtained through death certificate data collection.

More work could be done with the benefits survey (looking at what benefits employers are offering to their workers, including health insurance). R&P could analyze licensed occupations – including allied health professions -- further to address questions like, "What is the workforce in the healthcare system in Wyoming? What does it look like? What should it look like?"

The Board of Nursing research could be expanded with other licensing boards, matching licensing data with unemployment tax files and other states' data. High school and community college graduates could be tracked as they enter the workforce. Occupational projection data is used by the Department of Workforce services to determine whether a funding request for a training program by a community college is actually needed, and that could be specialized to the healthcare industry. Job listings information resides in a

database that could be scanned to identify current job openings. Utah is working on a mechanism to draw out skill sets so as you look across occupations, you could determine what skills are increasingly being sought. People are saying we have a shortage here while there's an oversupply a hundred miles away – how do you reconcile that?

Meanwhile, R&P can assist with providing insight regarding how Wyoming fits into the federal statistical system that drives national policy. If we're not attuned to what's going on at the national level, it's awfully difficult for us as a state to be a player. Regional networks also are important.

Mr. Bryce wanted to know if it's possible to take R&P people in benefits research and identify businesses that don't provide health insurance. Then, could R&P conduct focus groups to ask those businesses if they would "buy in" to a specific model of health benefits? Mr. Gallagher said his staff is well qualified to do that kind of research. Mr. Mossbrook wanted to know if the Commission were to come to the Department of Employment with a short-term research project, what kind of turn around would be required? Mr. Gallagher said two weeks, if some of his staff put in overtime.

There was discussion about how the Department of Health collects and reports information on people enrolled in state-funded healthcare coverage programs (Medicaid, State Children's Health Insurance Program (SCHIP)). Mr. Gallagher said there is a wealth of data collected in state government that isn't digested and applied to policy questions. Ms. Jenkins said she was looking into medical service inflation rates on the Bureau of Labor Statistics web site and wanted to know if Wyoming specific data is available (Mr. Gallagher said it isn't). Mr. Gallagher is participating in a 16-state consortium working to improve the local and regional data available. The consortium has some funding and technical support and will meet Feb. 18 to talk about how systems can be brought together so you can get what you're after and there's comparability between and across states.

Mr. Muirhead asked about the calculation of state income for the state/federal match to Medicaid. Mr. Gallagher said the number used is per capita income. The bulk of that information comes from unemployment income tax records. The Bureau of Labor Statistics sends it to Economic Analysis in the Commerce Department. That number is used to calculate the average wage. On top of that, to come up with total personal income, you add dividends, interest, rent, social security, and transfer payments, which probably isn't representative of average income in Wyoming. In Wyoming per capital income is partly driven by oil and gas royalty payments, which doesn't impact the average person. If one lacks understanding of the federal statistical system, you don't have the information you need to interact in federal policymaking.

Dr. Fleming said that the profile of poverty in the state is part of the problem with getting legislators to understand Medicaid projections. The way it's calculated doesn't formulate housing costs and other inflationary impacts on income. She said Mr. Gallagher was correct: the Department of Health has 80 different programs and depending on the funding source, there are different requirements for collection of data. The Department is

research and analysis poor, Dr. Fleming said. She asked that Mr. Gallagher meet with her staff about data sharing projects that will integrate data within the Department. Mr. Gallagher said the fruit the SPG should have borne goes right to that particular issue. He said an analyst is working on SPG-related work specific to employer attitudes. Dr. Childs wanted to know if R&P could track medical school students and residency program students and determine where they go across time, and Mr. Gallagher said funding would be needed to do that over a period of years.

Cheryl Koski, Director of the Board of Nursing, was introduced next, to present the research being done by the Department of Employment R&P on nursing workforce issues in Wyoming (**handout: Koski.pdf**). The Wyoming Commission on Nursing and Nursing Education (WCNNE), a private non-profit bringing together entities interested in nursing (Board of Nursing, Hospital Association, Wyoming Long-Term Care Association, deans and directors of all seven Community College and the University of Wyoming nursing education programs, advance practice nurses and others). Initially the group wanted to survey nurses regarding why they leave the state, and why they stay. They also wanted to know how many nurses are needed in the state. She discussed the process that went into developing the research project, including Attorney General approval of data sharing, and education of the researchers preparing to do the work and interpret the findings.

The result, *The Glover Study*, as it's known, was completed as the first phase of the research WCNNE sought from R&P and it has been used by policymakers across the state formulating the Wyoming Investment and Nursing Education law providing additional financial support for advancing the education of nurses and nursing faculty. The number of nursing education graduates who passed licensure exam and other supply side information is now available as a result of the partnership between R&P and WCNNE. *The Glover Study* showed there are enough nurses coming into the state to meet the demand but at the same time, nurses are going out of the state and eventually what's going to happen is the number leaving is going to exceed the number coming in. Licensure numbers in Wyoming are the highest they've been in the history of the state. Many of them are travelers coming into the state to work as nurses temporarily. What about the need for public health nurses, though? That's not been researched.

R&P is willing to work with WCNNE on statistically sound nursing surveys to find out why nurses are leaving. Funding has been obtained to repeat *The Glover Study* but regionalization of supply data can't be studied because there isn't any funding available, nor is there money to analyze how many applicants and how many qualified applicants seek slots in nursing education programs and are accepted, how many are funded by the new nursing education bill and how many want funding from the state, unemployment rates and nursing departure rates, employment outcomes of recent graduates, the reasons nurses are leaving the profession, nursing demand, etc.

Early, unofficial reports are that *Glover 2* (a second year analysis doing the same data gathering and analysis as done in *The Glover Study*) will show Wyoming is now 45th (up from 50th) in the nation for nursing salaries, while Colorado is 18th. Ms. Koski said when she's met with nursing school graduates, she's found few interested in staying in the

state. Funding is needed to serve the data needs of healthcare facilities facing health professional shortages; the state needs to develop an across-the-board formula that will help determine exactly how many positions are available within a profession and which professionals are in shortest supply. Five-year longitudinal data is needed to look at whether the nursing education legislation will help retain nurses and other strategies used by healthcare facilities are making a difference in retention. WCNNE wants to develop a strategic statewide plan for nursing manpower and provide leadership in nursing research and policy recommendations. She reviewed what other states are doing. WCNNE needs between $50,000 and $100,000 to do research – data collection and analysis, in addition to survey tool development. She talked about WCNNE's other needs, noting that she has, in her tenure, seen and weathered three nursing shortages in Wyoming. If WCNNE doesn't get funding and support, the quality of healthcare in the state will be impacted, she said. Adequate workforce data and planning is critical to the future of the profession in Wyoming.

Dr. Childs said the positive influx of nurses into the state is due to the presence of traveling nurses, and he asked what the cost to hospitals is for a traveler vs. an employee. Ms. Koski said travelers are coming in from other countries as well as across the nation. She said when training costs are factored in, as well as investment in the community and its people, it's difficult to value the difference between a traveler and a long-term employee. Ms. Jenkins said she just spoke to a Wyoming hospital administrator and he said they pay three times as much for a traveler as they do for a staff nurse. Mr. Muirhead said at Wyoming Medical Center, it's double.

Mr. Vandel wanted to know how many full FTE nurses there are in the state and Ms. Koski said that data isn't available from the Board of Nursing. Mr. Gallagher knows, however, she said. Mr. Mossbrook wanted to know what percentage of nurses educated here are leaving immediately after graduation (*see The Glover Study*). Assuming it's a very high number, would the information required to assess why they left the state after accepting a first position here be proprietary information of the hospitals they work at? Ms. Koski said if they want to provide that information on a survey, it would be up to the individual nurse. If we're educating them and we get first shot at them, Mr. Mossbrook said, and we're driving them off, we need to look at something very narrow, potentially. Mr. Gallagher said for the first three years they stay but after that, they make career choices and begin to move. Mr. Muirhead said maybe the incentives need to be brought in as nurses enter years four, five and six of employment rather than years one through three. Mr. Vandel said we're seeing a major need for nursing catch-up. Nurses work for years for low wages compared to others with similar education levels. They can go other places and make considerably more. Wyoming hospital reimbursements are too low to allow them to hike salaries. That's not logical, Dr. Childs said, because hospitals are paying large amounts for traveling nurses to fill slots that have been vacated.

Mr. Bill Sexton, Wyoming Behavioral Institute CEO and Wyoming Hospital Association Chairman-elect, introduced how a decision-support model is coming into the healthcare arena around public policy, what hospital CEOs are using information

technology to do, and asked **Mr. Bob Kidd (Wyoming Hospital Association President)** to present the history of information technology in hospitals in Wyoming.

Mr. Sexton said (**handout: Sexton.pdf**) healthcare is in the information business. Often in healthcare, however, decision makers fly by the seat other their pants and need increasing amounts of data which typically can't be obtained or it's discovered after the fact. He described health care information systems and what capacities they should have: span the entire health system from epidemiology studies to serve delivery outcomes, provide links to a broad range of planning agencies, providers and communities; meet the needs of all relevant groups; facilitate governmental, clinical and institutional quality of care decision-making, and utilize state of the art technology. He reviewed the questions that should go into decision-making: what are we doing, what should we be doing, how well are we doing, and how do we improve? Sources and users of data are consumers, payers, providers, regulatory agencies, researchers, communities, and healthcare planners. Areas that have standards with national reporting are epidemiology, insurance enrollment, service encounters, practice guidelines, human resource, organization, patient safety measures, key quality measures, clinical outcomes, report cards, performance measures, financial expectations. Typically, this data is "siloed"; there is no sharing across systems and this prevents a broad-based perspective.

Mr. Sexton used the 14th Annual Health Information Systems Leadership Report conducted in 2003 to show that facilities' CEOs are typically worrying about: Availability of staff (74%), Medicare cutbacks (57%), improving patient safety (57%), cost pressures (53%), satisfying customers (38%), improving operational efficiencies (36%), and improving quality of care (23%). Top 10 concerns faced by CEOs on a daily basis are physician relationships (57%), competitive profitability (35%), labor shortage (29%), clinical quality (25%), market share (24%), and revenue cycle (16%). For the most part, information technology supports their daily and long-term challenges only partially (69%), with 6% saying IT provides no support and 25% saying they get some support from IT. Business plans and information technology plans are not meshing in many of the respondents' facilities. Fifty three percent of the respondents say they plan to implement new systems in a multi-software environment, 46% plan to reduce medical errors through IT solutions, 41% will use IT to become HIPPA compliant, 35% will implement a computerized patient record and 33% will upgrade inpatient clinical systems. What is the anticipated future investment in information technology? System-wide clinical information system (52%), computer-based medical records (51%), computer-based practitioner order entry (47%), web-based clinical applications (46%), clinical data repository (36%). The most significant barriers to IT implementation are lack of financial support (25%), proof of real benefit (17%), lack of IT strategic plan (10%), lack of deliverable IT products (10%), and lack of common data standards (8%).

Mr. Sexton noted that IT has to compete with many other needs within limited budgets, staff often don't support investment in IT and IT's value is "stealth" (unseen). Small rural hospitals in particular struggle because effective systems are expensive. Nonetheless, hospital CEOs want to continue to invest in healthcare information technology and 59%

responding to the survey say they'll increase their allocations in their budgets to cover the additional cost.

Mr. Bob Kidd said Gov. Ed Herschler appointed a blue-ribbon healthcare committee in the 1980s to address healthcare systems issues. At that time, they wanted to look at a rate-setting commission for healthcare providers in Wyoming. A contract with a Harvard Medical School consultant resulted in a recommendation that Wyoming didn't need rate setting – and the complaint that it had one of the poorest information systems regarding what was going on in healthcare system. The Wyoming Healthcare Data Authority was created and funded ($50,000) with an eye toward Certificates of Need. But then CONs were repealed federally and so the Wyoming Authority was sunsetted. There was still no way to pull together patient profiles for a patient abstract. The Databank Program in use in 30 states is available to Wyoming hospitals now (general acute care hospitals) via the Wyoming Hospital Association. After the Authority was sunsetted, the WHA entered into a contract with the state, making the WHA the repository for hospital data for the state Department of Health. That data, which includes patient profiles and healthcare utilization patterns (where they go for care, what type of care is provided, etc.) has been used for development of the SCHIP program, and physician peer review in hospitals, for example.

Wyoming Health Resources Network (WHRN) was created in the 1990s to assist in creating health professional databases. The Wyoming Health Information Network (WHIN) also was created composed of Blue Cross Blue Shield, Wyoming Medical Society, Wyoming Hospital Association and the Department of Health, with funding coming from the private sector, but nothing happened because collection of data was so expensive. WHIN money was given to WHRN and WHRN contracted with the University of Wyoming, which created the Center for Rural Health Education and Research.

Mr. Kidd noted there are no health economists or health statisticians in the state, even at the University. The closest we have are epidemiologists. When you look at building a public policy database, you need to look at what it's going to cost, is data going to be collected on an ongoing basis and once you do that, how are you going to analyze and understand it? Attempts to get funding for staff economists and statisticians in the Department of Health have failed. A catalog of the data collected by the Department of Health resulted from a $100,000 Montana-Pacific Quality Healthcare Foundation study in the 1990s. The federal government has an unbelievable cost-related database, Mr. Kidd said, because Medicaid and Medicare fund so many patients' care. Forget about getting information from individual physician's practices, he said. It's too onerous for them to contemplate.

Mr. Mossbrook wanted to know if there were outside firms to send data to for statistical and economic analysis. Mr. Kidd said there are, but that service is expensive. Mr. Sexton said using data in the decision-making process is a 15-year implementation. Mr. Kidd said the national healthcare data initiative is collecting data for quality indicators. Twenty hospitals in Wyoming are participating in that effort. Mr. Bryce wanted to know whether

there would be cost containment savings as a result of IT implementation. Mr. Sexton said there is evidence that evidence based and best practice model application is beginning to show results for both cost containment and better patient reports. But, Mr. Kidd, said, sometimes by improving care, costs increase. There are some unknown variables in what IT will do for healthcare and its cost.

Dr. Hank Gardner and Alfrieda Gonzales, representing the Wyoming State Planning Office, presented an update on the Wyoming Health Information Network. Ms. Gonzales said that it is not the WHIN that Mr. Kidd referenced but is a new, Gov. Freudenthal-driven initiative. Some of the data and information that's available to the state and will be a valuable tool is becoming available at a critical time as other states are facing operation deficits in healthcare and making indiscriminate cuts in programs. WHIN is an information-driven approach to finding health care cost containment solutions. Ms. Gonzales introduced Dr. Gardner who is acting as a consultant to private sector employers and the state with finding answers to the healthcare cost containment issue.

Dr. Gardner reviewed national health care statistics indicating the nation's death rate is flat lined, while the country has been medicalized and the cost of health care has advanced. Government has been trying to solve this for 100 years. He reviewed national policymaking that resulted in "price fixing," subsidization of medical providers overcapitalizing the system (no rational decision making based on the market), and incentives built into the disability system to drive "extra consumption." The most rapidly increasing medical cost in this country is medical care associated with automobile accidents, he noted, and employers are paying increasing amounts for a full spectrum of benefits including health insurance and worker's compensation. The reimbursement model at the same time has driven payments toward hospitals and away from primary care and prevention and wellness. For example, most insurance covers 100% of hospitalization and lesser amounts, if anything (when a deductible is factored in) for primary care and prevention and wellness. Human capital management is a "win-win" for workers and employers because it restores the market to health benefits consumption decisions. More government isn't in the answer, more market is (understanding price, competition, personal preference and the market). We think you can get more for less because we are spending so much now it is riskier to consume than to not consume. When people are not at work and not productive and their employers are paying for their benefits, we are not getting return in terms of productivity return on investment.

One of the goals of WHIN is to look at claims benefits across programs (worker's comp, unemployment, Medicaid) and to move to a "Human Capital Management Approach" with emphasis on "a day's pay for a day's work." The data going in includes State Auditor's Office payroll data, state employee compensation and benefits, Medicaid, retirement, worker's comp, Department of Family Services, and Department of Workforce Services. It is pooled with information on 8 million corporate employees' "benchmark data" from across the country. Data has been collected on 16,000 state employees and dependents who are insured by the state, 15,500 workers' comp claimants, 61,700 Medicaid claimants, and employed populations in rural and larger town settings. Dr. Gardner estimated that represents 20 percent of the population. He showed

the relationship of Wyoming's base salary to benefits. He said if salaries weren't increased, it would be difficult to recruit and retain workers in Wyoming as the private sector moves up the Front Range and begins to imbed in Wyoming. He displayed a graphic showing Wyoming's salaries to be significantly lower than other states'. As we look at this within the framework of economic development, we have got to compete for better human capital in the state and with it will come the need for better health services.

You cannot divorce health care and it's relationship to health from health care and economic development. If you look at the use of sick leave by job band, people who earn less use more sick leave, he demonstrated statistically. It's because we're not paying them enough to be at work. If they're using their sick leave, they're going to be using healthcare services. Those who earn more in contrast use annual leave. His data also shows 24% of Wyoming employees are using 80% of the benefits available, and the largest portion of those benefits is health care coverage. From a policy point of view, one thinks, "I ought to understand that population a lot better." Take this a step further in terms of lost time, about 17 percent of the workers were there everyday (no lost time, in terms of sick leave). The sick leave benefit for the state of Wyoming is 100 percent of pay, which doesn't make a lot of sense in terms of a day's work for a day's pay. Another 46% used less than 4 days, while 1.1% used a whole lot of worker's comp. We would argue you should roll all benefits into a paid-time-off package. Past analysis showed that less than 5% of those taking sick leave in the private sector actually went to the doctor. We need to look at paying people more to do better work and less for time off. In terms of state employees, if almost 60% are not having lost time problems, how do we better understand those who are?

He noted that present programs designed to create medical savings accounts for employees puts in too much money, based on their average costs, for healthy people and leaves the unhealthy to rely on insurance. We have an assumption if you're on Medicaid or Medicare you're sick and everyone's equally sick, not so. What we've found is that Medicaid clients are not sicker but they go to the emergency room for treatment because we have squeezed the reimbursement to primary care providers so much, they won't take them. The Medicaid population is distributed about the same as the state health plan in terms of population, but Medicaid is about 20% more costly. National data shows a lot more people need physician services than nursing facilities and home health care, but more dollars are going to nursing facilities and home health care than physician services.

Dr. Gardner talked about the fact that doctors and patients don't really know what health care costs. Management policies result in practices within businesses that may generate higher claims for worker's comp. The asymmetries in information prevent knowledge of population patterns. We need to look at integrated management between health care and worker's comp in Wyoming. There's about 10 percent to 15 percent efficiency in looking at health and leave benefits that Wyoming could achieve, he said. If you pay people to be sick, some will choose to be sick. He compared Wyoming to an analysis he did for Federal Express. He noted that company's worker's comp costs expanded disproportionately because FedEx contracted with an HMO and the HMO had a physician staffing the contract who could collect a larger fee if the case was classified as

worker's comp. Since the physician had a financial incentive to submit work-related injury claims to workers comp rather than processing charges for the same treatments through the health benefit plan, there was a demonstrated tendency for medical conditions—even conditions like clinical depression—to be categorized as work-related. People who learn how to consume and develop consumption capital use up a greater share of the benefits. Dr. Gardner's example illustrated that a failure to look at the whole picture might reduce costs in one area, only to have them shift to or actually increase significantly in another. However, using disability incentive management, FedEx has been able to show a reduction in leave of absence days, an increase in transition-return-to-work, and reduced healthcare costs over the course of six years. Dependent healthcare costs stayed stable at the same time. FedEx changed the medical absence policy limiting full-pay leave days to five. The prediction there would be improved attendance, less disability, less health insurance and less worker's comp and $20 million in productivity savings. The cumulative savings was $860 million over eight years.

Agency analysis in Wyoming will show overlap between income, job training, Medicaid and worker's comp. Access will be broadened and redefined. FedEx used the data to decide to hire more part-time employees (who have access to health insurance, but not disability benefits) than more full-time employees (who cost more on a per-unit basis, in terms of benefits). He said changes occur within six to 12 months in corporations with targeted management. There is opportunity to be creative, he said, with the state's Medicaid "tab" in much the same way.

Two speakers presented the opposing sides of the bill now before Congress to create association health plans (AHPs). **Kristi Wallin of the Alliance to Protect Your Healthcare** (925 national and local organizations banding together to oppose this bill) said the lack of state oversight is among the issues leading to opposition. Her organization's belief is that skyrocketing insurance premiums are likely to impact AHP members because there is no regulation of their premiums and practices. Small employers could offer AHPs to healthy people and then shift them to the state regulated market when illness occurred. There would be a loss of right to an external review of a denied claim. The fiscal soundness of the AHPs would not be assured and health care providers might not get paid. Many medical procedures would not be provided to employees whose employers' were without bargaining power for a broader spectrum of services covered.

State Associations like the one **National Federation of Independent Businesses (NFIB) state President Tom Jones** heads up could be in the position of making money by selling these insurance policies to their members, Ms. Wallin said. Wyoming is in the fight between both sides because there are fewer health insurance programs available and costs are higher, due to the number of small businesses and the state's low population (and small pools). Ms. Wallin said Wyoming Sen. Mike Enzi is on a committee assigned to consider the proposed legislation. She provided the Commission with letters and newspaper articles supporting her case. She called on Sen. Charles Scott, in the audience, as another opponent to AHP. He said the National Conference of State Legislatures opposes the legislation fearing that associations will systematically pick off the healthy groups and offer them a significantly lower rate and then leave Wyoming's small group

market with a sick population that can't be afforded and the number of uninsured will increase. The key is a rate band protection that keeps pricing controlled, he said. A second problem is the lack of adequate financial solvency regulation. Insurance is uniquely at risk because you pay for it once and you get the benefits down the road. The company may underestimate future costs and go break legitimately or be subject to fraud. State insurance regulation was developed to prevent that set of problems.

Mr. Mossbrook asked if there had been amendments to the legislation to address state regulation and protect consumers. What's Enzi say when you talk to him about adding an amendment?, he asked. Ms. Wallin said another state's senator has been working on some alternatives. Ms. Wallin said she has a letter from Sen. Enzi addressing those concerns and she may be able to answer Mr. Mossbrook's questions later.

Tom Jones, NFIB Executive Director, brought the Commission information about health insurance costs. If you don't bear the burden, you tend to abuse the benefit, he said. Causes of health insurance unaffordability include federal and state mandates for coverage. The effect of the mandates increase the number of uninsured, Mr. Jones said. The role of the AHP is to provide choice, which leads to competition, and small business deserves treatment equal to what large businesses get. Small businesses are limited in the number of companies offering insurance (13). There is limited flexibility within available plans. Blue Cross Blue Shield has 40 percent of the market and was responsible for the Alliance to Protect Your Healthcare's presentation, he said. Large businesses can self-insure under ERISA plans, have freedom from mandates, lower insurance costs and can cross state lines. The suggestion that AHP's will cherry pick healthier people is a myth, Mr. Jones said, because laws are in place to prevent that from occurring. He refuted studies that show the number of uninsured would increase if legislation passed allowing AHPs. Self insured AHPs will have explicit solvency requirements that are much stronger than current law for large businesses and unions that self insure. He read from the House legislation that has passed and is now in the Senate's hands. The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in relation to an employee's health. AHPs can only generate a set of rates for all insured groups within the plan based upon the overall claims experience of the entire AHP. If you can combine people across state lines, you can increase the number of lives insured and the larger pool spreads the loss ratio across a wider spectrum of health statuses.

Yes, AHPs will pre-empt state mandates and that is why we would like to do it, because large businesses can already do that under ERISA and small businesses can't. AHP sponsors must be bona fide professionals or trade associations, not organized for the purpose of offering insurance, he said. Just like other self-insured plans governed by ERISA, self insured AHPs will be regulated by the Department of Labor. Under AHPs, small business owners and their employees will reap the benefits, not associations. I'm not going to tell you AHPs are a total solution. I'm not sure there is one. We do believe AHPs are part of the solution that will bring some choice to businesses and their employees and give rise to some competition. This will lower administrative costs, avoid mandates, and allow small businesses treatment equal to large businesses. Mr. Jones was

asked what the differences are between the House and Senate versions of the bill and he said he wasn't sure about what those are.

Tom Lubnau, attorney, president of the Wyoming State Bar, and firefighter from Gillette, presented lessons in threat and error management science from the fire service. While Mr. Lubnau is associated with groups like the Wyoming State Bar and the Gillette fire department, he made it very clear that he is speaking only for himself in this presentation and is not speaking on behalf of or representing the views of these groups.

Five years ago yesterday, he was called to a burning one-month-old modular home caused by a woodstove flue next to a floor joist. The home fell on top of Mr. Lubnau when he went in to save it and he was injured. He cited other examples of situations where firefighters were injured and/or died in situations that might have been preventable. He then described a body of evidence developed by the airline industry in response to a set of avoidable accidents. He described the body of human knowledge as Swiss cheese and accidents as those events that go through the holes. If you take away the fire helmet or airplane and substitute medicine, it's the same. He said he's been involved in numerous medical malpractice cases and is convinced firefighting, airlines and medicine are interchangeable because human error can result in death, humans are in charge and are the decision makers and stressful situations are inherent in the work.

Stack up Swiss cheese and the holes cover each other up and the bad event doesn't happen. Human beings in stressful situations react in predictable and quantifiable ways. Errors are inevitable. Systems should be designed to account for those errors. Crew Resource Management (CRM), implemented by the airline industry and in its infancy in firefighting, is not just another safety program. It requires a change in the culture. CRM is the application of human factors science to a group of people to encourage the optimum utilization of resources to achieve desired results in a high consequence scenario, reducing accidents 80 percent. Good leaders are already using these techniques, which have been around for thousands of years. Communication is taught: inquiry, advocacy and conflict resolution as a means of helping lower level people overcome hierarchical barriers. The traditional autocratic leader is missing opportunities to get the valuable information they need. Followership is also taught – an individual is responsible for their training, physical condition and mental condition, hazardous attitudes (anti-authority, impulsivity, etc.). Decision making models that call for evaluating choices, assessing consequences and arriving at a learned conclusion don't work in stressful situations. Through our experience, training, briefing and there are series of patterns created in a person's mind that are used as a basis for decision making in emergency situations. There may be more time than thought to make a decision but the perception is that there is no time. Near Miss Reporting is used by the aviation (NASA) industry. When a regulation is violated, the pilots can self report and when they do they are given a confidential number so that if somebody reports them and it's already been reported they can hold up the number and say, "nope, won't go against my license, I've already reported it." There are 10,000 non-consequence events before you have death. A database of errors and near misses is created.

Does CRM training apply to the medical community? Cultural change is hard. Is an 80 percent reduction in errors, injuries and deaths something worth exploring? Initiatives being set up nationwide (Jackson Hospital, Miami, University of Texas, Robert Helmreich, Institute of Medicine – To Err is Human: Building A Safer Health System). Sen. Scott asked how legislators could influence the system so that the kind of thing Lubnau described actually happens. Mr. Lubnau said he's given a lot of thought to that. He thinks doctors get a grade of fair in enforcing quality. If you give them the self-reporting data (no consequences for reporting), that will help. He said he doesn't know if CRM can be legislated. Everyone is concerned about patient safety. Get buy in by documenting statistically you help the patients out and it makes the doctors lives simpler. Mr. Vandel asked Sen. Scott if his legislation includes a no-fault component and the Senator said yes, and the structuring of a health care errors commission to review situations where injury occurred. But changing culture is still the issue. The medical culture implicitly suggests doctors are infallible. Expectation of infallibility prevents reporting of errors.

Mr. Bryce asked if a team of professionals is working on a surgery, is any one member frowned upon for saying "that doesn't look quite right" or do most people have an openness that says "let's collaborate." UW's Jim Paige said the medical professional historically is hierarchical; saying anything that's contrary to whoever is in charge is not permissible. Sen. Scott said a doctor from Johns Hopkins speaking at Wyoming Medical Center recently said that a checklist like pilots use in an operating room enforced by nurses resulted in knockdown, drag out arguments sometimes not resolved until a surgeon retired. Dr. Stacy said if he's operating and an anesthesiologist suggested he wasn't doing something right, he would discount that but if his assistant, even a Physician Assistant, made a suggestion, he would listen to that. One of his mentors was a nurse, saying I learned from a nurse who had learned from other doctors. The nature of the training at major universities is the top-down, God-like behavior but when you go into practice, doctors who succeed tend to lose that. Dr. John Harper asked about the cost of malpractice insurance's bearing on the issue.

Dick Williams, attorney and Vice President of Human Resources & Legal Services, Wyoming Medical Center, said he began his career in private practice doing medical malpractice defense in Casper. He went full time at WMC about 10 years ago. One of the duties he signed up for was risk management. When he began doing risk management in 1994, it was reactive. Then he did occurrence trending, but that was after the fact. That began to change in 1996 when the Joint Commission began accrediting hospitals, when the role of risk management changed and was elevated. Their sentinel event policy was that if you had a sentinel event in a hospital, the hospital was required to complete a root cause analysis of the event, document, analyze and educate. That's a tedious process. Follow-up takes five or six times as much time as the investigation. But that begins to change the mindset. That was the first time we began to see a requirement for a look at the system as opposed to a look at the occurrence. Most hospitals, fearing use of their reports in litigation, don't report sentinel investigations. Next, a non-punitive reporting process was developed. We have never fired a nurse at WMC for a medication error, yet

there is a belief and there is fear of reprisal for coming forth with an admission of that kind of error.

The next iteration was in 2003 with the establishment of the national patient safety goals after the Joint Commission reviewed about 2000 sentinel events. Hospitals were required to adopt those six goals and a seventh added in 2004, and to appoint a patient safety officer. A new standard, the unanticipated outcomes standard, requires physicians to meet with patients and disclose what occurred. Overall, it has increased credibility and accountability. I have some concern still how it affects subsequent litigation and that remains to be seen. On the quality side I have also seen a significant change since I started in 1994. Hospitals have always collected quality data but for the most part didn't know what to do with it. There's been more focused collection of data and collection of more meaningful data. We're seeing some real changes there. One of the nuances in the hospital setting that is not present in other businesses is we have one group of very powerful influential people who participate in our process who are not our employees: physicians. We don't have the kind of control that you would have over your employees. It's key to changing any clinical process to have physician support. Physicians have no problem supporting the change if there is science to support the change. The Catch-22 is we need their help in collecting the outcomes data. Help means time. It's very, very difficult to have enough hours in the day to move as quickly as we would like to move. As we begin looking at best practices not as cookbook medicine but as giving the best outcomes, that's also partly driven by the economics.

He said a major obstacle to reducing errors would be removed when nurses can call a supervisor or a physician in the middle of the night and not fear a negative reaction. He described the accreditation review process and the results it has in hospital procedure. Mr. Mossbrook asked what the greatest areas of risk are in a hospital. Mr. Williams said in terms of serious claims over the last ten years, it has been a combination of failure of nursing staff to recognize the severity of a condition, breakdown in communications between staff and physicians and a hesitancy to talk to physicians. He said he's seen only one medication-error related claim in the last 10 years. I think it's primarily communication issues and communication between nursing staff and physicians, he said. Dr. Fleming asked if Mr. Williams would report back in the future on the hospital's error rate as new models are implemented. Discussion followed regarding the resources WMC dedicates to this process and Mr. Williams said he wonders how smaller hospitals can afford to do risk management now.

Ken Vines, Wyoming Insurance Commissioner, was asked to speak about the OHIC response to the Commission's inquiry several months ago. In looking at non-economic damages vs. economic damages, it's difficult to gather data because most companies don't gather or provide that information. OHIC did attempt to do that and provided documentation to the Commission (**handout: Vines.pdf**.) OHIC has been licensed in Wyoming since the early 80s but did not start writing policies until the early to mid-90s. Data was provided from 1991 to 2002. He reviewed aggregate data for settlements and judgments, and defense costs and other expenses for those years. The figures for non-economic and economic damages left the Insurance Commissioner with some questions

and he has a request for information pending with OHIC. He's asked to know how they got the numbers they provided since they don't track that information and what was provided doesn't tally up. What's of interest is being able to match the premium against the amount paid out in claims. Just a brief explanation: there are several sets of information here. There are two kinds of medical malpractice policies, occurrence and claims made. The data provided shows the volatility of med mal in Wyoming.

Mr. Mossbrook asked if The Doctor's Co. also let few cases go to juries? Mr. Vines said pretty much, although that doesn't tell you how many cases they would have prevailed in had they taken a case to trial. The only jury payout OHIC shows is $90,000 (and there is no indication whether this is one case or multiple cases) and the The Doctor's Co. reports none. Sen. Scott said if you wanted to know the profitability of the insurance company's business in Wyoming, you'd also need to know general administrative expenses and the value of their investments. Mr. Vines said he thought in some instances that may have been factored in. The Insurance Department provided that information last year. Companies are required by regulators to invest their surplus. You want that money there when they have to pay claims.

An actuary in Salt Lake City, Glenn Taylor, consulting actuary for the Department of Insurance, sent a response to a set of questions presented to him by the Commission regarding the medical malpractice insurance industry (**Vines2.pdf**). He said annual and quarterly statements filed with the Insurance Department are limited on Wyoming-specific information but can be of use when looking at an insurance company's solvency. Rate filings with the Department of Insurance have Wyoming-specific information and should be used to determine whether companies are paying out more than they are collecting in premiums. He reviewed the data commonly tracked internally by most med mal insurers and the key variables the insurers track. He responded to why insurance companies continue to do business in Wyoming while losing money by explaining what occurs in the insurance business cycle. Discussion followed concerning the insurance industry's activity in "hard" and "soft" markets.

Insurance companies use Wyoming specific data when setting rates, but because Wyoming's numbers are so small there has to be some regionalization and countrywide data to be statistically significant (which may benefit Wyoming in some respects). The consultant said that doctors are not supposed to be paying wide differences in cost for insurance for similar specialties, policies and claims histories; doctors should report anomalies and make complaints to the Insurance Commissioner and the Insurance Department. With underwriting, they do make specific risk characterization using information like historical claims data. Other questions answered by the actuary were reviewed, including how "tail" coverage is calculated, how rising medical costs impact insurance rates, and what kinds of data Wyoming policy makers need to make informed decisions about med mal insurance. Mr. Taylor says that most information needed is already available. He did suggest the Commission ask companies to more fully disclose which other states' experiences are included in their ratemaking processes to assist nonactuaries in understanding the calculations.

Audience comments and questions: No one asked to address the Commission.

The next Commission meeting will be Feb. 23 in the Herschler Building, Room 1299 in Cheyenne. A national group, Common Good, will be participating in a discussion along with Gov. Mike Sullivan and legal and medical interest groups during the Commission meeting. On March 22, the Commission will again meet in Casper at the UW Outreach Building.

Meeting adjourned, 4:06 p.m.