Wyoming Healthcare Commission Meeting Minutes
Jan. 23-24, 2005
Cheyenne, WY

Attendance

T. Chris Muirhead, Chairman, Steve Mossbrook, Vice Chairman, George Bryce, Marlene Ethier, Jack Glode, M.D., Carol Jenkins, Paul Lang, Jack Speight, John Vandel, Commissioners, Deborah Fleming, Ph.D., Wyoming Department of Health Director and Ken Vines, Wyoming Insurance Commissioner, Ex-Officio Commissioners, Anne Ladd, Director, Emily Genoff, Assistant Director, and Jan Kruse, Project Coordinator.

Meeting called to order at 8 a.m. by Chairman Muirhead

Two of the Commission's subcommittees met Sunday evening and again Monday morning from 8:10 to 10 a.m. The results of their work is reported in the Committee Reports section below.

Iris Oleske, State Medicaid Officer, Wyoming Department of Health (Handout: Medicaid 101)

Ms. Oleske provided a "short course" on Medicaid to acquaint the Commission with how the program operates in Wyoming. Medicaid is called "EqualityCare" here, because of Wyoming's identity as the Equality State. Medicaid is not welfare. Medicaid was delinked from the welfare system in 1996, although the Department of Family Services (DFS) processes eligibility determination for Medicaid under an agreement with the Department of Health (WDH), she said.

Medicaid's mission is to provide quality healthcare services to low-income individuals in the most medically appropriate and cost-effective manner, Ms. Oleske said. EqualityCare enrolls providers willing to provide services at Medicaid reimbursement rates. EqualityCare's enrollment rate is 100 percent for in-state hospitals and primary care physicians -- including ob-gyns, pediatricians, and internists, pharmacies, and nursing facilities. Medicaid is the payer of last resort and collects from estates, trusts, accidents and other legal liability claims, she said.

EqualityCare is the smallest Medicaid program in America, Ms. Oleske said. Its current biennium appropriation (through June 2006) is $722 million and an additional $72 million has been requested, for a total budget of $400 million a year of which 90 percent stays in state. Out of state providers are not a large proportion overall, she said. Administrative costs are low – 95 percent of the budget goes into direct case services. If it were not for HIPAA, administration would run about 4 percent of the total appropriation, Ms. Oleske said. Those dollar amounts include a federal match monies ($435 million, or 60.3 percent of the total), which are decreasing in proportion because

Wyoming's economy is getting better and the feds pay more in states with less robust per capita incomes, she said.

In FY 2005, there were more than 75,000 individuals enrolled in EqualityCare and the average monthly eligible caseload has increased to 59,404. Medicaid's Management Information System processes 3 million provider claims per year, Ms. Oleske said. Medicaid pays for 63 percent of all Wyoming nursing facility days in the state (nationally it is about 50 percent), 12 percent of all hospital days, and 47 percent of all Wyoming births (compared with 33 percent nationally), she said. Wyoming has the highest income eligibility rate in the country – 133 percent of the Federal Poverty Level (FPL). Medicaid provides home and community-based support services for 3,100 elderly and disabled Wyoming residents, 54,000 children and families and 3,200 foster care and special needs children. Children living in foster care often have significant mental health needs and may require extended inpatient care, Ms. Oleske said. The aged and disabled cost significantly more than the other Medicaid populations.

To be eligible for Medicaid, people must be U.S. citizens or qualifying refugees or aliens, live in or express an intent to live in Wyoming, be blind, disabled, aged, pregnant or dependent children, meet financial requirements, and/or meet medical necessity requirements, she said. Income guidelines (about 46 percent of FPL) for adults preclude most people who are not pregnant or disabled from enrolling. Children ages 6 to 18 qualify at a higher income level (up to 100 percent of poverty), and pregnant women, newborns and children under age 6 are allowed in at an even higher income level (133 percent of FPL), Ms. Oleske said. There is no coverage available for non-disabled childless adults. Wyoming has five "waivers" that provide home and community-based services to individuals who would otherwise be institutionalized: elderly and physically disabled people 19 and older, people in assisted living facilities, developmentally disabled children and adults, and people with brain injuries, she said.

Ms. Oleske reviewed the populations who are covered by Medicaid in other states but not in Wyoming. Federal law prevents discriminating against people when limiting services funded with Medicaid – the amount, duration of scope of each service provided must be sufficient to reasonably achieve its purpose. Physician visits, for example, are limited to 12 per year to discourage overuse but limits may be waived if more care is needed. Reimbursement to providers must be sufficient to guarantee beneficiaries' access to services. Cost sharing can only be nominal and does not apply to pregnant women, children under age 18, and nursing home patients who contribute most of their income to care, or for emergency or family planning services, Ms. Oleske said.

Mandatory Medicaid services include family planning, physicians, dental surgery, emergency and administrative transportation, and early and periodic screening, diagnostic and treatment (EPSDT) for children 21 and younger. Health insurance companies, by comparison, are not going to pay for administrative transportation or EPSDT, Ms. Oleske said. Services that are optional, under federal rules, for adults include prescription drugs (although all 50 states provide coverage), physical therapy by an independent provider, prosthetics and orthotics, audiologists' services and hearing aids, optometry, hospice and

organ transplants. Services that are mandatory for children are organ transplants, extended inpatient psychiatric services in a hospital or residential treatment center, eyeglasses, speech therapy, comprehensive dental, private duty nursing, and allied health professionals' services (chiropractor, podiatry, social workers and dieticians). Mandatory services comprise 61 percent of Medicaid's budget, she said.

Medicaid attempts to reimburse at a level that will encourage participation by providers. Reimbursement by law must be sufficient to maintain services to the Medicaid population at least to the extent they are available to the entire population, Ms. Oleske said. However, providers must bill any other insurance for services before billing Medicaid (with some exceptions), and providers must accept Medicaid payment as payment in full for Medicaid covered services with no balance billing to beneficiaries (and providers are encouraged to bill at "usual and customary" rates), she said. Some reimbursement is cost based (inpatient/outpatient, hospital, nursing facility), some is fee based (physician, dentist, other practitioners and therapists, waiver, home health, mental health), and some is market based (prescription drugs), Ms. Oleske said. Inpatient hospital cost coverage is currently 83 percent of actual costs and more than $5.4 million would be required to cover 100 percent of actual costs (allowable costs, which is not the same as the cost of doing business – bad debt, depreciation, write-offs – 70 percent of the cost of doing business is reimbursed by Medicaid, maybe). Outpatient hospital cost coverage is 51 percent of actual costs, physicians and other practitioners receive about 53 percent of billed charges, and about 77 percent of dental services' billed charges are covered by Medicaid, she said. Discussion followed regarding reimbursement rates, Wyoming's efforts to increase the funding available to providers for treating Medicaid consumers and the recent push for additional dollars for dentistry.

Medicaid pays more than private insurers for prescriptions. Average Wholesale Price (AWP) is established by the drug industry, not by the marketplace. Medicaid programs cannot restrict drug coverage to a set formulary, Ms. Oleske said. Discussion focused on Medicaid's prescription spending. Wyoming only reimburses pharmacies at 11 percent of the AWP, plus a $5 dispensing fee, requires prior authorization of non-preferred drugs, is looking into a multi-state purchasing cooperative. Ms. Oleske detailed the problems with the Medicare prescription drug bill; about 7,000 Wyoming Medicaid "dual eligibles" (eligible for Medicare and Medicaid benefits) will be impacted.

Medicaid policy concerns include cost containment without detriment to patient care, appropriate coverage for low-income families, and continued assistance for the elderly and disabled with a rapidly aging state population. Cost containment initiatives include use of an evidence-based preferred drug list and pharmacy case management for high utilizers, and "total health management" services for those with chronic illness. Ms. Oleske spelled out fiscal pressures and state and national issues impacting Medicaid program funding and management. There is flexibility through "waivers" and the Healthcare Commission is working with WDH on finding new waiver options for expanding coverage to the uninsured. Ms. Oleske said Medicaid is working to minimize cost-shifting of the cost of care from the state-covered individual to the uninsured individual by providers.

Linda O'Grady, Senior Health Policy Analyst, Medicaid, Wyoming Department of Health (Handout available at http://wyominguninsured.state.wy.us)

Ms. O'Grady presented the Medicaid Waiver Expansion Study funded by the Health Resources and Services Administration State Planning Grant (SPG), and released in 2005. The SPG Task Force completed its work in late 2003 and recommendations were made by the Healthcare Commission to the 2004 Legislature based on the Task Force's work. The Task Force's research also was the basis for choosing models to evaluate in the Medicaid Waiver Expansion Study – identifying who might be the best populations to cover with a waiver, who might be likely to enroll and what it might cost. Policy goals have to be set to determine which options might best fit with a state's opportunities to change the type of services delivered to specific populations, Ms. O'Grady said.

This study concentrates on two types of waivers: Section 1115 allows for a redesign of a current program within a current budget, while a 1115 HIFAA waiver (Health Insurance Flexibility and Accountability Act) allows for expansion of people covered and can be used to maximize private insurance, Ms. O'Grady said. Waivers approved by the federal government don't permit waiving all federal rules and require some matching funds from SCHIP or other Medicaid dollars. HIFAA waivers reduce cost-sharing and benefit requirements for states. Estimated program costs are contained within the study, prepared by Milliman (an actuarial firm) using three different types of benefit packages. Ms. O'Grady detailed the contents of the study, which is posted on the state's SPG web site and was completed under contract by Navigant Consulting, Inc. She said with the Bush administration's appointment of a new Secretary of Health and Human Services, there may be changes to the 1115 Waiver process. Waiver application may be a lengthy process.

Sen. Charles Scott, Co-Chair, Joint Labor, Health and Social Services Committee

Sen. Scott apologized for the absence of Committee Co-Chair Rep. Doug Osborn, who could not attend due to a lunch-hour committee meeting. Sen. Scott said the Legislature's unfolding agenda for healthcare cost control is thin but significant. In the arena of prescription drugs, the basic strategy Wyoming has adopted is a free market approach, trying to get information on pharmaceuticals into the hands of those making decisions about what to prescribe (PharmAssist has saved more than $2,000 per person served already this year). A bill was introduced to try to control pharmaceutical companies' marketing practices in the state but was defeated 14-13 by the full Senate due to opposition from drug companies and the medical profession. A budget footnote may require WDH to survey and publicize pharmaceutical costs in Wyoming to influence prescribing practices.

Senate File 77, an uncompensated trauma care bill drafted in part based on WHCC recommendations, is in the Senate Appropriations Committee, now. Only half the proposed funding is left in it, but it has a good chance of success due to the information Commissioner Bryce developed using Navigant Consulting uncompensated trauma care study report findings on cost shifting (for more information, visit

www.wyominghealthcarecommission.org, “reports”, Uncompensated Trauma and Catastrophic Care Study). Commissioner Bryce’s graph depicts market share and cost shifting by individual components of the healthcare system – and that Medicare and Medicaid are forcing up insureds’ costs. Commissioner Bryce noted that Navigant Consulting has been asked to expand on its uncompensated care study to look at all hospital discharges rather than just trauma-related care. Within a week, the Commission hopes to have more information about uncompensated care costs, outside of trauma care. Sen. Scott said he is eager to see the results of that work.

Sen. Scott said a bill that would allow for use of medication aides in nursing homes instead of nurses for some job duties is “violently” opposed by nurses, apparently largely due to economic issues for the profession. Due to the national nursing shortage, there would seem to be a need to reduce the demand for nurses by allowing people with lesser training to perform some functions. He predicted that in general, efforts to control healthcare costs through legislation will fail because when you control costs, you’re controlling somebody’s income and those people are likely to appear in the lobby. He said policymakers know with the United States’ system spending 50 percent more than anybody else’s system on healthcare, things need to be done -- but it’s going to be a battle. With respect to the physician shortage in the state, in Casper there are 3,000 or more people who by Feb. 25 will not have and will not be ablet to get a primary care doctor. Physician practices are overwhelmed and are trying to absorb some of the patients without care, but it is difficult to get in to see a doctor. Patients covered by Medicare are particularly challenged in their efforts to find a medical home. He predicted the shortage is going to spread, Sen. Scott said.

Wyoming legislators are not having much success with trying to control malpractice liability insurance costs. Attorneys are opposed to it and they seem to have a majority, Sen. Scott said. For example, the expert witness bill is dead and loss of chance bill is dead in one house, he said. He noted that the Commission’s research on what other states have done with regard to medical review panels has been useful to him. The passage of Amendment C on the General Election ballot has generated three medical review bills which are competing and may have to be decided in conference committee. One of the issues is whether or not the findings of the panels is admissible in any ensuing civil suits. The Governor intrigued the Legislature with the idea of allowing evidence that can be used to impeach expert witnesses to be admissible (rather than all review panel evidence), Sen. Scott said. He said his bill, Senate File 141 (http://legisweb.state.wy.us/2005/digest/SF0141.htm) provides for alternative dispute resolution if malpractice is established, making it “fiercer” than bills proposed by Sen. Kit Jennings (Senate File 62, http://legisweb.state.wy.us/2005/Introduced/SF0062.pdf) and the Joint Judiciary Interim Committee (House Bill 83, http://legisweb.state.wy.us/2005/Introduced/HB0083.pdf). Sen. Scott said his bill also has one component absent in the others and that is to use the state health officer to take advantage of what may be learned about medical errors by having a medical review panel, and get some feedback into changing the medical system so those errors are not repeated. “As you know, this has been a theme of mine. I don’t know if I’m going to get

support for that. There's been some sentiment that 'let's keep it clean and simple' so we can get something passed," he said.

Commissioner Speight said it is important that there be a cutoff date for malpractice actions with a medical review panel in place as a portion of the process for settling claims. He also asked about the composition of the panels and Sen. Scott said the three bills vary. He said he thinks we need to get away from the lawyers vs. physicians debate. There are differences regarding how to finance the panels as well.

A bill that passed the Senate on regulating malpractice insurers which would prevent some of the abuses of individual physicians particularly in the tail coverage area but it isn't going to make a tremendous amount of difference, Sen. Scott said. One bill is being crafted with the intent of assisting recruitment of physicians, and there are a number of bills would enable other healthcare professions to do things now that just the doctors do (examples the Senator gave include expanding the number of physician assistants a physician can supervise, revising the nurse practice act to cut nurses loose to allow advance nurse practitioners independence from physicians, expanding the scope of practice for psychologists and podiatrists).

The Medicaid ticket-to-work bill is likely to pass and is one effort to allow flexibility within that program. Sen. Scott said he opposes efforts of the federal government to force more of the cost of Medicaid back on the states. "I'm going to be opposed to waivers that expand our coverage until the feds do away caps on federal share. I don't want to see the state-federal partnership destroyed and the feds are seeking to do that."

As a sidebar, he said, the recently approved Medicare Part D is of concern to him: "I'm sure nobody understands the new regulations. The state has some responsibilities and is having some difficulty getting ready. My prediction is that when that goes into effect Jan. 1, 2006, there's going to be chaos. I don't see how they can implement a program of that magnitude. It is way too complicated. They're going to ask somebody who's 75 and not used to dealing with government to file the proper things in the proper places? It's not going to happen. You're going to have a period of six months or a year where that thing is just an awful mess, even under the best circumstances. We are forbidden to cover the prescription drugs of people with dual eligibility in our Medicaid program after Jan. 1. I don't see how they're all going to get properly eligible for Medicare Part D on Jan. 1. I think we need to set aside some state money to deal with the problems in the interim so we don't have poor seniors losing coverage during the chaos. We need to have some contingency money the Health Department or Governor can use because I can just see a wreck coming, Sen. Scott said.

Reviewing the list of bills recommended by the Commission, he said that a budget footnote will need to be added to assure funding for a study of the cost of physicians and other providers' uncompensated trauma care costs – only hospitals were studied initially. Efforts to strengthen auto insurance coverage requirements (House Bill 169) are going to be contested. The argument is going to be that Wyoming already has too much trouble getting people to buy the necessary insurance and increasing penalties and limits for

insurance is just going to create more evasion. Concerning the closed claim statute, Senate File 88 only fishes for more information some of which is simply not going to be available. The bill also does not deal with the plaintiff's side at all; it's very unbalanced. "I signed an approval form on a closed claim bill today that will have the Insurance Commissioner put together a report on both sides – defense costs, plaintiff's side, the settlements, the attorneys' fees in summary, and the expense of the system and how much actually gets to the injured party. I hope to get that introduced within the week," Sen. Scott said. Commissioner Speight said a letter is going to the Wyoming Supreme Court from the Commission asking that it mandate the reporting of that information not in summary but on an individual case by case basis.

The proposed chewing tobacco tax increase (House Bill 242) is meeting resistance. There are three methamphetamine (meth) precursor bills coming that are going to be introduced in the House (House Bill 100, House Bill 249, House Bill 293). Sen. Scott said he suspects one will pass. The main flow of meth that's used is coming up from Mexico, she said. There are a number of bills in the works in the whole area of meth. The Senate Judiciary defeated a bill aimed at prevention of use of meth by identifying kids at circuit court level by assessing them and figuring out which ones are risk of proceeding to harder drugs, including meth, and use the hammer of probation to force them into treatment. The Legislature received an Attorney General's opinion that was induced by DFS that opposed the bill. The message hasn't penetrated the Legislature as to the extent of the problem the state has with the drug, Sen. Scott said.

The medical errors bill will be up for consideration in the Senate Labor, Health and Social Services Committee on Wednesday (Senate File 113). "We're going to take a hard look at that," Sen. Scott said. "This whole area needs quite a bit of attention. We can't deal with the malpractice end of it but there's an awful lot you can do. The one thing I would say in summary is that I am deeply concerned that this session of the Legislature first doesn't have the tools and is going to be unable to deal effectively with the growing physician shortage and the way the medical community is unraveling. We're going to see the crisis play out. Without a constitutional amendment, we may not have an adequate solution available to us – although any amendment proposed shouldn't deal with capping non-economic damages because the people spoke on that in the General Election.

"I had hoped the pressure on legislators by constituents to control health care costs had mounted but apparently it hasn't enough to defeat lobbying pressure resulting from that fact that one person's costs is another person's income. We're going to have considerably difficulty dealing with the uninsured until we get a handle on the rising cost of state programs. You have a cost that is rising at between 7 percent and 10 percent a year as a general proposition so you've got a prescription for a budget buster you can't afford. Cost control is an absolute prerequisite. Failure to progress in that arena rules out major efforts to deal with the uninsured," he said.

Sen. Scott thanked the Commission for its work, said what is being done is exactly what's needed and asked the group to carry on with its efforts.

Chairman Muirhead's report

The Commission met in November and December to create a vision and action plan. New Director Ladd has been working with the Commission to prepare a budget, which just passed out of the Joint Appropriations Committee with a DO PASS recommendation *(handout: Commission budget).* Subcommittees are working on action plans and a two-page summary is available to better explain anticipated activities in the coming months (*handout: Legislative Summary of the Wyoming Healthcare Commission Action Plan for 2005 and the first half of 2006).*

Committee reports

Dr. Geoff Smith, M.D., Chairman, Information Technology Technical Management Subcommittee (Handout: Sat. Jan. 22, Information Technology Technical Management Subcommitee meeting minutes)

Dr. Smith provided an update on the work completed on the study required by Enrolled Act 31. John Snow, Inc. (JSI) has been contracted with to do much of the work needed to plan for a statewide electronic health record system. JSI has been researching regulations and funding for electronic health records, and identifying stakeholders in Wyoming who need to be incorporated in the planning process.

Dr. Smith asked Sen. Mike Enzi's office in Washington, D.C., to identify and invite a U.S. Department of Health and Human Services spokesman to present at the Information Technology Technical Management Subcommittee meeting Jan. 22, 2005, in Casper. HHS sent Lori Evans, MPH, MPP, Senior Advisor for Programs in the U.S. HHS Office of the National Coordinator for Health Information Technology (ONCHIT) to review the federal government's status with regard to electronic health records. ONCHIT is coordinating its electronic health records initiative through regional health information organizations (RHIOs) that will be accredited for federal funding. The consensus at the end of the meeting was Wyoming should pursue a RHIO. The feds do not have their RHIO accreditation package put together but we're on their radar screen; we'll be keeping on pace with the federal government so we're sure to be in line information about RHIOs as it becomes available.

Brian Baum of the Duke University Fuqua School of Business and Chief Executive Officer of the Health Records Network Foundation presented efforts to launch market-driven (consumer-based) electronic health record pilots in Wyoming, at Duke University and in Canada.

Also on Saturday, JSI sent its corporate team to provide an update on the work that company will do in the next few weeks. JSI will be in the state surveying stakeholders in the near future – particularly larger agencies involved in healthcare less directly than the Wyoming Department of Health and hospitals (i.e. the prison system). We'll be hearing more as they go around and knock on doors. The next big step may be in two different venues. He expects this spring to have a draft of the planning document that the

Subcommittee will widely disseminate and have public town hall meetings on to get reactions from the greater populace.

Commissioner Roberts, Chairman, Medical Errors and Patient Safety

Commissioner Roberts reviewed her committee's identification of key personnel to assist with her committee's efforts to complete the assignments in Special Session Enrolled Act 2, Section 1. A key to the process has been the Commission's contract for consulting services with Michelle Mello at Harvard University, an expert in the medical errors arena. In addition, Fran Cadez, manager of the WDH Office of Telemedicine, is "on loan" to the Commission to be the project coordinator for the Medical Errors and Patient Safety Committee. Ms. Cadez said she is tasked with running a large federal project for next 18 months intended to support technology for the advancement of access and quality in healthcare. She is an attorney, who, prior to working for WDH, was the first executive director of the Wyoming Worker's Comp Safety and Medical Commission, an administrative forum for medically contested cases.

(Handout: Medical Errors and Patient Safety) Ms. Cadez said the Enrolled Act 2, Section 1 study will look at identification, classification and reporting of medical errors, and identify and analyze methods of alternative compensation for medical injury. Research shows there is little if any correlation between medical malpractice litigation and medical errors. Malpractice premiums are not experience rated so there is not a huge deterrent effect imbedded in insurance premiums for error reduction. Malpractice insurance premiums go to insurance overhead (20 percent), legal fees (40 percent), and injured patients (40 percent). It is not known whether providers will change their behavior in response to risk or a result of the cost of litigation.

Alternative compensation systems are designed to have medical error decisions made by trained adjudicators, based on a standard of care broader than negligence but not strict liability, decisions are based on evidence-based criteria and guidelines for compensating economic and non-economic loss. Research is showing that there are different ways to classify medical errors – adverse events seem to be human and systematic. The compensability of errors concerns the negligence standard and preventability or avoid-ability.

The Institute for Healthcare Improvement (www.ihi.org/) has identified six areas for prevention, and the Joint Commission on Accreditation of Healthcare Organization (www.jcaho.org) and Leapfrog Group for Patient Safety (www.leapfrog.org) are entering arena of medical errors prevention. Issues surrounding reducing medical errors result in questions about how to report them (mandatory vs. voluntary reporting, confidentiality, ease of data entry, whether there is rapid, meaningful feedback, whether the goal of reporting is punitive or educational in nature, under-reporting concerns and whether medical errors damages compensation are linked).

Discussion followed regarding the committee's efforts to view addressing medical errors as important as the right thing to do, not a means of healing the tort system's problems and reducing medical malpractice liability costs.

Commissioner Lang, Healthcare Access and Affordability (Supply Side Studies)

Commissioner Lang said his committee's priorities are:

- completion of the rural health study launched last year by the Commission that should be nearing presentation in the next month, with a draft before the WHCC at its February meeting,
- a detailed inventory of the state's healthcare resources -- predominantly to be completed by staff and pulled together late in the summer,
- an outline within the next couple of months regarding what a Wyoming Health Policy Board could look like if such a body were created to efficiently coordinate parts of the state's healthcare resources, and
- continued effort to study recruitment and retention of healthcare professionals -- with one component being analysis of the utilization of the WICHE and WWAMI programs for medical education in the state, as well as dentistry and nursing education. Medical education research will be led by Commissioner Ethier.

Commissioner Lang expects his Committee to have recommendations formulated by late fall.

Commissioner Bryce, Affordable Healthcare Coverage (Demand Side)

Commissioner Bryce asked the rhetorical question: Can we get more people covered with quality health care coverage and quality care and can it be affordable? To that end, there are four different parts his subcommittee will examine:

1. In Wyoming, 96.5 percent of the employable population is employed; turning our backs on the employer-provided health benefits system seems self defeating. Tax smart accounts dubbed WYO CARE accounts are flex spending accounts, health reimbursement arrangements and health savings accounts eventually rolled into one simplified account that can receive contributions from multiple sources and a part-time employer. The accumulation of dollars is essential. Last week in Washington, D.C., Commissioner Bryce met with senators from Idaho, Montana, and Wyoming to discuss this multiple payer concept and combining the accounts. Currently, there are three different sets of reports that must be provided to the government to provide a health savings account plan like this. The senators agreed they ought to be able to get something reasonable like this done.
2. In the purchasing coop, there are a couple of things that have to happen. The number of insurance carriers in Wyoming has dwindled from more than 50 to somewhere between four and 13, depending on the type of coverage being provided, that are offering care in the small group and individual market. We want to build something that carriers will want to be part of. We will meet with the four carriers who are primarily involved and hopefully another two or three that should be involved with plans in the state and hopefully get them involved.

We want to build something that invites them to play as opposed to give them a reason to leave. The last thing we want to do is chase away the few who have hung in there to provide coverage to the small group market.

3. Part of that is reworking the reinsurance mechanism. There are two, covering the Wyoming Health Insurance Pool (WHIP) and small group pool. The hope is the WHIP can be reworked to reduce premium costs. The assessment last year was $1.6 million for 720 people. The small group mechanism covers 29 people out of a potential 30,000, indicating it's not set up properly. We're getting the top 1,000th of 1 percent participating in that pool. We're looking at a way to expand that pool to spread the risk of the worst risks among a higher base. One of the methods we are going to look at is a plan they used in Idaho, where 25 percent of the state's premium tax receipts from liability insurance (all types, including automobile) are allocated into that pool to subsidize the premiums and cover the deficiencies inevitable in the pools. We want to explore that with actuaries, the other states that have done it and next year's Legislature.
4. The committee is also looking at a quality care organization/pool and 1115 waivers in attempt to expand coverage of Medicaid to people without insurance. We want to see some coordination with free clinics and school-based health clinics to deliver care with Medicaid billing assisting to help defray the cost.

Chairman Muirhead, Medical Liability and Uncompensated Healthcare

Chairman Muirhead last year submitted a request for an Attorney General's opinion on the constitutional worthiness of an uncompensated trauma care bill (like Senate File 77) that would compensate hospitals for care provided to individuals who are in poverty without adequate healthcare coverage to fund their bills. The AG's opinion *(handout: AG's opinion)* suggests the trauma care compensation bill as drafted should stand up to challenges that it might not be constitutional. The opinion isn't binding, Commissioner Speight noted, but can be used to support a recommendation/bill. As long as any recommendation/bill is couched in terms of assisting the poor, it should meet the constitutional test. The AG's opinion concludes it is reasonable to assume a program funded with state money could be approved to help the poor even if doctors or hospitals are direct beneficiaries, as long as the patients are income eligible. Discussion followed regarding whether the uncompensated trauma care fund should be a continuing program or short-term fix.

Audience questions and comments

None made

Medical licensure study

The WHCC plans to release a study by a University of Wyoming law student regarding medical professional licensure in the state and whether there are unnecessary hindrances within regulation or law to getting a license to practice in Wyoming. The study

conclusion contains three recommendations which will be made public prior to the next WHCC meeting.

Meeting adjourned, 3 p.m.

Next WHCC meeting:
Feb. 27-28, Cheyenne, Wyoming

Note: To obtain copies of handouts, please use the "search" function on the Commission's web site, or email whcc@state.wy.us to request a hard copy.