Wyoming Healthcare Commission
Feb. 13, 2006
Meeting Minutes
Cheyenne

Attendance:
Dixie Roberts, Chairman; Rex Arney, Rod Barton, Barbara Cohee, Jack Glode, M.D., Carol Jenkins, Steve Mossbrook, Barb Rea, Lorraine Saulino-Klein, John Vandel, Commissioners; Ken Vines, state Insurance Commissioner, Brent Sherard, M.D., Department of Health Director, Ex-Officio Commissioners; and Emily Genoff, Assistant Director, and Keith Hageman, Executive Assistant, WHCC staff.

Guests:
Ginny Mahoney, Bev Morrow, and Linda O'Grady, Wyoming Department of Health; Rick Rush, Leif and Associates; Bob Kidd, Wyoming Hospital Association; Jerry Calkins, M.D.; Bernadette Quevedo-Mendoza, CMS; John McBride and Rick Schum, Blue Cross Blue Shield; Lloyd Wilder, Wyoming Insurance Department; Jerry Kiplinger and Chris Sullivan, APS; Beth Wasson and Lori Jasperson, WIN Health Partners; Marcia Shanor and Steve Simonton, Wyoming Trial Lawyers Association; Pennie Hunt, Wyoming Health Resources Network; Susie Pouliot, Wyoming Medical Society; Wendy Curran, Governor's Office, Dr. Hank Gardner, Human Capital Management Services.

Meeting called to order by Chairman Roberts

Advance Directives Registry
Commissioners were split into four groups to work on a Request for Proposals for an advance directives registry, for collecting and housing information about individuals' "do not resuscitate" orders and living wills. The groups reviewed their work, reporting on who would benefit from an advance directives registry, unintended consequences of a registry, cost savings (direct and indirect), budget considerations, and next steps. The groups defined the registry and its purpose.

Summary of group findings, and consensus points:

- The registry would have benefit as a tool for medical care providers,
- For the registry to have value, however, extensive and cost education initiatives will be required targeting:
    - Providers, to assure that they use the registry and
    - Consumers, to encourage their provision of living wills and like documents to the registry
- The registry database will:
    - need a home, besides the Healthcare Commission
    - be continuously updated to assure consumers' mind changes are accommodated and build consumer and provider trust
    - be secure, to build consumer and provider trust
- Funding is needed for the registry to operate, regardless of where it is based
    - The registry should be low cost or free to assure access for all consumers

- Registrants will need an identifier (sticker for driver's license, for example)
- There are not standards for advance directives registries
- A statewide electronic health records network will incorporate advance directives, eventually negating the need for a separate registry.

Reinsurance (powerpoint)
A reinsurance bill is expected during the 2006 Wyoming legislative session. Reinsurance is a means of reducing health care coverage risks by assuring payment for high cost claims; Wyoming has two reinsured pools – one for small employers and another for high risk individuals who cannot buy coverage on the market.

Rick Rush of Leif and Associates reviewed a study conducted last year for the Commission on reinsurance and its value as a tool for designing programs for covering the uninsured. The state small group insurance pool's report for Jan. 1, 2002, through Dec. 31, 2004, was distributed by the Wyoming Department of Insurance, prepared by the Wyoming Small Employer Health Insurance Program Board of Directors (attached). The program currently has 28 lives covered.

Mr. Rush said reinsurance spreads the risk, splitting costs among parties, but without cost and quality management, the overall rate of health care cost increases will surpass the impact of reinsurance savings. The state needs to look at a lot of other things that control health care costs; reinsurance is not a panacea, although it may be a tool in conjunction with cost containment strategies.

A number of states have offered, but dropped, reinsurance pools; participation is low. However, carriers offering healthcare coverage in Wyoming surveyed by Leif and Associates report they do not think Wyoming should drop its small employer reinsurance program. Even though carriers pay for it through premium assessments and mostly do not utilize it, they want the option available to them.

Leif and Associates used interviews with Wyoming's carriers and claims data to look at Wyoming health care costs. Leif found the average claim cost per member per month is $211.82, so when estimating what it costs to cover a life in Wyoming, in 2003 and 2004 it was $211.82 plus profit and administrative costs. Twenty percent of the people drove 76 percent of the costs; 20 percent had claims exceeding $1,774 per year.

A reinsurance model subsidized by taxpayers already operating is Healthy New York, where the state pays the reinsurance premium for a certain set of individuals with a requirement that carriers offer a premium within a specific price range. Healthy New York targets the uninsured and has 100,000 enrollees. Premiums are about 20 percent lower than the marketplace is offering. Small employers and individuals not offered coverage by employers are eligible.

Small market share by state
The top five insurance carriers state by state, on average, have 75 percent of the small employer market:

- Wyoming has 12 carriers licensed to sell small employer coverage, and the largest has 40 percent while the top five comprise 74 percent of the market.
- Colorado has 27 licensed small employer carriers, but the top five have 72 percent of the market.
- In Idaho, 97 percent of the small group market is served by the top five carriers.
- In Utah, there are 22 carriers and 93 percent of the market is served by the top five carriers.

There's nothing that indicates Wyoming is not competitive for insurance companies; the state's marketplace is as competitive or lacking competition as other market places.

Sen. Charles Scott, Legislative Update
Sen. Scott reviewed the legislation impacting the Healthcare Commission or resulting from its work:

- The Wyoming Health Information Technology Technical Management Committee's Healthcare Information Technology bill (Senate File 50) may be daunting, due to its magnitude and price tag. He is confident that bill will not be fully funded, but hopeful that at least part will be funded. They may not go with the hub and spoke concept as recommended by the consultants, but for the most efficient and cost effective way to accomplish the same goal.
- The Commission's reauthorization legislation (Senate File 48) may be in jeopardy because there is opposition with the Joint Appropriations Committee to the Commission's existence. The Commission's budget was deleted from the Governor's budget, and will have to be passed with the reauthorization bill. Sen. Scott will meet with Commission Chairman Roberts to review components of the bill that may need amending.
- A bill to study specialty hospital introduction in the state was triggered by a proposal for a new hospital in Casper.
- Senator Scott said he would add an appropriation of $75,000 to the Department of Health budget for the biennium to accommodate a person to manage the Advance Directives Registry. Steve Mossbrook and Dr. Sherard agreed this would be appropriate.

Discussion followed regarding the state's budget; the Legislature's 2006 budget session kicked off with the Governor's message today. The state of Wyoming has a $1.8 billion surplus, Sen. Scott said. Of that, $2.1 billion will be budgeted in ongoing operating expenses. The state is extraordinarily dependent on natural gas; a $1 fluctuation in the price of natural gas equals $1 million in state revenue, Sen. Scott said. Natural gas has historically been very volatile. A $3 fluctuation could put the state from surplus to deficit, almost overnight, he said. Some precautions are going to be taken in legislation to make sure that if there is a disaster, the state is prepared. The debate is how much and how to save the money.

Insurance data
Chairman Roberts asked the Commissioners to prepare for Dr. Hank Gardner's presentation of health care costs in Wyoming and the potential for using his data for

benefits modeling by reviewing last month's work and the components chosen as the basis for establishing insurance coverage values.

The Commission decided in January that its priority between now and June is to figure out ways to insure the uninsured and reduce costs. In order to do that, the following must occur:

- Define basic health care and what is a right and what is a privilege, and build in:
  - early prevention,
  - risk stratifying,
  - total health management,
  - informed consumers,
  - debate of the merits of subsides/mandates;
- Define cost savings (formula = healthcare consumed x cost per unit + administrative costs), with provision of:
  - transparency,
  - optimized utilization (demand incentives, supply incentives),
  - limited administrative costs,
  - use of technology,
  - consumer information regarding access, price and quality,
  - statewide clinical guidelines collaborative;
- Define data benefits, and a structure:
  - Provide administrative infrastructure to identify and set evidence based guidelines,
  - Cost management
  - Affordable reporting systems,
    - What do consumers want
    - What will they use
  - Provide consumer tools
  - Benefit design

Dr. Hank Gardner, Health and Human Capital Management (powerpoint)
Dr. Gardner reviewed his background, areas of expertise and clientele. A gastroenterologist, Dr. Gardner was raised in Star Valley by educator parents and did his pre-medical education at the University of Wyoming. He has invested himself over the course of his career in health professions education, health care organization and finance (sole proprietor and director of the first federally qualified HMO in the early to mid-70s), a health information service business, and "health and human capital" research and development. He sells a database service with analytic information decision support to large employers -- including the state of Wyoming, research services with outcomes distribution, health as human capital core research, and human capital management consultation services. His company is based in Cheyenne.

Dr. Gardner explained he starts with people data (human capital data integration) and helps firms with workforce recruitment and retention, individual health and productivity, health benefits performance, safety performance, as well as business profitability and government accountability. The new frontier for benefits design includes income

indexing and customization of cost share, based on income level. In an integrated database, worker's comp, case and disease management data, and safety data are combined with worker demographics. The HCMS research reference database includes payroll and demographics information on 515,000 workers across the country, information about 541,000 insured dependents, and millions of people's medical insurance, prescription drug coverage, and sick leave and other absences. The Wyoming departments of family services, workforce services and corrections, and Medicaid data is available to HCMS to analyze with respect to state and national trends and indicators. There is no database that is comparable in other states.

Dr. Gardner reported year's worth of Wyoming social agency expenditures shows that of the money spent, 93 percent was for medical care (72.4 percent Medicaid, 20.6 worker's comp), while 4 percent was spent on food stamps, 2.1 percent on child care, and less than 1 percent apiece on welfare and on workforce training. Life expectancy gains in the United States have largely come from clean water, public education and other programs not specific to medical care. When people are doing better financially they use health services less. We don't get more by spending more; we get more by spending less if we are selective in spending less.

The medical paradigm has been around since 1933. When medicine becomes free, utilization increases. Year one preventive service expenditures ($400) reduce total health costs 15 percent the next year. The $400 expenditure should be customized to the individual. Prevention resources have to fit age and other risk factors. If you spend too much, you lose the marginal benefit, Dr. Gardner said.

In Wyoming, the medical care dollars are spent as follows:

- 1.6 percent for prevention,
- 8.6 percent for cognitive services,
- 89 percent for technical and institutional care.

Analytics have turned up troublesome trends:

- More resources are spent on fewer people at the expense of the majority;
- More resources are expended on drugs, diagnostic and therapeutic, technical and institutional services at the expense of preventive and cognitive caring services;
- More resources expended on the chronically disabled and elderly at the expense of human capital investments in children and families.

The paradigm shift is from a medical/disease paradigm to health as human capital paradigm, with the primary focus on:

- market information problem,
- what kind of person and family needs,
- comprehensive incentives centric,
- focus on prevention, and
- a risk-based, Pareto approach.

Our fragmented medical system does not deal with the complicated needs to the medically costly clients using the majority of the resources, Dr. Gardner said. The new "consumer centric" health insurance prolongs the cost share, preventive services are free, and a pre-tax Health Savings Account is built in.

A consumer model has to integrate the following:

- Have consumers pay directly for most care, with some economic responsibility for every transaction,
- Create more direct transactions between providers and patients,
- Connect provider payment more to outcomes and less to activity,
- Reduce or eliminate the number of third party participating in the health services consumption process, and
- Generate portability.

Consumer health account incentives are on:

- conservation of resources,
- focus on prevention,
- promoting choice and price competition,
- integrated with other health benefits (sick leave, disability, worker's comp) and
- financial accounting of consumption.

The banks know how to do administrative transactions, and are interested in managing HSAs and have a chance at managing them aggressively like they manage 401K accounts.

The insurance and managed care focus is on:

- hurry through the cost share and deductible so the consumer price goes to zero,
- focus on disease diagnosis and treatment,
- directed care with negotiated networks,
- incremental administrative managed care, and
- third party administrator claims processing (layering on costs).

The insurance industry is measured by top line -- costs go up, premiums go up -- which grows when you have more dollars passing through.

Poly pharmacy pilot
The state is collaborating on case management of Medicaid and other agency clients using more than 12 medications, managing them to assure medication compliance, to reduce adverse drug events and to connect them with services they need to address the issues resulting in their medication. The pilot is going to be an information, education and decision support service delivered by a team of pharmacists and nurses, in consumers' homes. Two hundred people are targeted for the pilot.

Wrap up
The March meeting date has not been set. Commissioners will be polled to set a date. The meeting will be in Casper.