Wyoming Healthcare Commission
September 25-26, 2005
Rock Springs, Wyoming

September 25, 2005

Attendance:

T. Chris Muirhead, Chairman, George B. Bryce, Marlene Ethier, Jack Glode, M.D., Carol Jenkins, Lorraine Saulino-Klein, Steve Mossbrook, Dixie Roberts, John Vandel, Commissioners, Ken Vines, Insurance Commissioner, Dr. Brent Sherard, Department of Health, Ex-Officio, Julie Sapp, Governor's staff, Anne Ladd, Emily Genoff, Fran Cadez, Claire Brockbank and Michele Patarino, WHCC staff. Representatives of the public in attendance were Steve Chasson, Beth Wasson, Lynn Birleffi, Jan Drury, Richard Rush, Nelle Johnson, and John McBride.

The meeting was called to order by Chairman Muirhead.

Mr. Muirhead said the day would begin with a review of WyoCare, a mechanism for expanding healthcare coverage for people in Wyoming without insurance. WyoCare was the primary topic of a meeting between Anne Ladd, Claire Brockbank, George Bryce, Mr. Muirhead, Governor Dave Freudenthal, Dr. Hank Gardner and Julie Sapp on Friday, Sept. 23, in Cheyenne. It was agreed on Friday, Sept. 23, that Dr. Gardner – a researcher addressing health data issues for the Governor's office -- would be collaborating on WyoCare, and there would be greater involvement with the state employee health plan led by Ralph Hayes.

Review of Commission work plans and timelines for 2005-06

WyoCare -- Claire Brockbank presented a draft work plan and timeline for WyoCare, which was built around a "straw man" concept implementation framework presented at the August Commission meeting. The WyoCare draft work plan and timeline have already been set in motion; the document distributed outlines a set of decision steps that need to be analyzed to allow the Commission and Governor by June 2006 to have enough information to draw conclusions and determine a course of action for reaching the working uninsured/small group population.

Discussion concerned the integration of Dr. Gardner's data and his findings specific to insuring the working poor, which will now be incorporated into WyoCare's vision and goals. Therefore, the timeline as presented may be optimistic. The underlying assumption is that no proposal for reaching the uninsured will be made or considered as having potential unless it can be shown that it will reduce the upward trend in health insurance premium costs. Dr. Jack Glode said people are dropping insurance because of cost, not value; value is not an issue in the market. Affordability is the key, he said. Ms. Brockbank said that other states introduced barebones, low-cost plans that no one bought.

The first piece of the straw man concept implementation plan and timeline is analysis of the opportunities to maximize reinsurance programs and possibilities in Wyoming. Reinsurance is one means of subsidizing high cost claims to potentially lower premium costs as carriers recognize reduced risk. Insurance Commissioner Vines said he thinks reinsurance is a critical means of reducing the rate of health insurance premium increases. He says WyoCare gives the Commission and state a "vessel" for trying clinical guidelines and other tools for controlling healthcare costs, but making reinsurance and/or subsidizing premiums will be considered friendly and inviting to insurers.

Ms. Brockbank and Ms. Ladd noted that Sen. Charles Scott has requested data that is being gathered for presentation in October, the sum of which will allow modeling of different scenarios and expected attached costs. The economic impact of sliding fee scale premium assistance is going to be analyzed to determine how to bolster the likelihood of insurance purchase by employees now electing to go without coverage due to its cost.

Ms. Jenkins said the Commissioners need to have a clear understanding of the underlying objectives for WyoCare. Is the mechanism for expanding coverage needed primarily to reach the uninsured in general, who may or may not be low income? Are the uninsured working poor uninsured? Or, is WyoCare a vehicle for health insurance quality improvement? Ms. Brockbank said the guiding principle the subcommittee designing WyoCare has used targets the working uninsured. Mechanisms that change consumer health-preserving behavior will have a "trickle out" effect, lowering overall costs and increasing the amount of coverage available to more people.

The majority of the estimated 82,000 uninsured fall in the small group market, Mr. Bryce and Ms. Brockbank said. State health insurance premium subsidy must go toward the shift from preventive maintenance of high claims costs to a long-term savings through good health practices. Taking the high dollar losses off insurers and putting them on the back of government maintains the status quo, Mr. Mossbrook said. The marriage between reinsurance analysis – projecting what will impact premiums – with a benefit plan that values prevention will have that effect, Ms. Brockbank said. The cost per unit of care is not going to go down, Ms. Ladd said.

Actuarial help will be sought when population targets are more clearly defined, to determine the shape of the program that is to be made available to the target population. High deductible health plans may have a different impact; consumer sensitivity to price is still being assessed. In the end, "a leap of faith" may still be necessary since predictive modeling cannot anticipate every variable, Ms. Brockbank said.

Formal WyoCare structuring and financing will depend some on the regulations of state and federal government attached to Health Savings Accounts (HSAs). A law firm is working with the subcommittee on understanding the potential for HSAs. Mr. Bryce said he hopes that the existing insurance carrier market will form a purchasing pool in Wyoming to serve WyoCare, thereby preventing WyoCare from having to be an insurance offering entity in its own right.

Public information dissemination and feedback gathering will need to be led by Commissioners. Mr. Mossbrook said the lack of "true" public comment during the Information Technology Technical Management Committee's electronic health records public meetings concerns him. Getting true public comment will require getting out of the public hearing box; he proposed dovetailing with other major human resources meetings, broker trainings, and other gatherings of professionals likely to be impacted by the opportunity presented by WyoCare. Ms. Roberts said relationships need to be built with employers and business owners in the state. Discussion followed regarding reaching CEOs and the power that they have, and legislators.

Part of the long term plan for WyoCare, although only now loosely defined, is a course of communication with medical care providers regarding their participation in the WyoCare model, Ms. Brockbank said. Consumer incentives for practicing healthy behavior also need to be factored into the WyoCare model. Discussion followed regarding amounts paid for different types of medical care and the means of limiting cost shifting.

Eligibility and participation rules will sift out as WyoCare's economic modeling continues, Ms. Brockbank said. Dr. Glode asked who would make the determination of eligibility; would the entire small group market be in WyoCare? The objective is not to allow insurers in the purchasing pool to pick and choose who they want to cover, Mr. Bryce said. If employed uninsured people create WyoCare accounts into which money is placed for the purchase of premiums that are managed by a trust, the trust document will determine who is eligible, he said. Built in is the need to meet with current health insurance carriers to find out what will make the marketplace work better on a voluntary basis and what pieces will have to be mandatory, Mr. Bryce said.

Evidenced based medicine includes a clinical based guideline collaborative that has a separate timeline, Ms. Brockbank said. Looking at with health plans operating in the state already have clinical guidelines, what their track records are, and what data they have, will be elemental. The objective in the end is to be able to say whether total health management as described within the WyoCare concept will impact the healthcare claims cost trend line. "The question is, what could you do to get the leaders in the field talking to health plans so that at the end we have to best of our ability put data out and tried to quantify the 'goods' and 'bads' of total health management," she said.

> **Comments from the public:** Lynn Birleffi, representing America's Health Insurance Plans and the Wyoming restaurant and merchants associations, said she and her staff have been at all Commission meetings and participated in subcommittee discussions about WyoCare. Nonetheless, more input is needed to effectively capture the opinions and viewpoints of insurers, she said. She offered the Commission a short presentation from health insurance companies' government policy people on WyoCare and total health management. "I could bring in someone nationally who has worked with a lot of these kinds of plans," she said. Total health management, evidence based medicine, reinsurance, accountability for care are helpful in containing health care premium increases,

she said. But WyoCare has become so broad, it is difficult to explain. Whether the small group market should be brought in is a big question. She said there is concern among those she has talked with regarding the potential for WyoCare creating a new level of cost shifting.

Actuarial consultant Rick Rush of Leif and Associates in Colorado said actuarial estimates indicate 18 months to three years will pass before there is any impact on trend lines from reinsurance subsidy.

Beth Wasson of WIN Health Partners in Cheyenne said she would participate in a presentation to the Commission regarding insurance companies' perspectives on WyoCare. She said she was surprised at the straw man concept implementation description and is not completely comfortable with it. She would like the opportunity to talk about what is going on in the market with the carriers – some of what is being discussed is already being done. Subsidies and reinsurance would help, however. Mandating fee schedules and designing benefit plans will impact the balance in the state that exists, Ms. Wasson said. The market could be disrupted if reimbursement structures are changed. Thirty percent of WIN Health's membership is people who were previously uninsured.

Commissioners' comments: Marlene Ethier said considering what has happened with WyoCare already makes her think what is outlined in timeline is a lot to accomplish in a short amount of time. Mr. Vandel said sometimes a deadline draws the attention of those who are impacted and generates a reaction when previously there had been no comment. Mr. Bryce said the Governor wanted the WyoCare plan on a fast track and that has served its purpose. "We have to keep going in this direction with guidance to figure out what pool is the best pool to play in and we shouldn't stop," he said. Ms. Roberts said Commissioners are themselves just evaluating the fleshed out WyoCare and will welcome the public's input.

Mr. Mossbrook asked if carriers would be willing to reveal what they pay for different services. Ms. Wasson said fee schedules are proprietary. "We struggle with not having a competitive market in Wyoming, which is a downfall," she said. Doctors can set their rates however they like. That is one of the things insurers count on to make a product work, so they have to be proprietary, she said. Ms. Ethier said no one has a good feel for what things cost when purchasing medical care. John McBride of Blue Cross Blue Shield said the reason medical prices are shielded is because the consumer is not talking to the doctor about what it will cost for particular types of treatment – a third party payor comes in and negotiates the price and pays. What would be desirable would be for consumers to communicate directly with providers about costs and be responsible for paying the bill. Blue Cross cannot talk with WIN Health about prices because of anti-trust rules. Blue Cross is prepared to meet with Ms. Brockbank and Mr. Bryce on cost information directly but won't throw it out to the public, Mr. McBride said.

Ms. Jenkins said there is pricing information available if you call and ask the hospital and physician. Ms. Mossbrook disagreed. Discussion followed regarding what information is available and to whom. Mr. McBride said Blue Cross Blue Shield sees value in a set fee schedule. He thinks that is a good way to control costs. Consumers/patients care about co-pay levels, not the price of the actual service or prescription. Fee schedules do not matter, Dr. Glode said. Physicians can charge whatever they want but they will not collect the difference between what insurers pay and the cost of the service. Manipulating fee schedules and patient portions of the medical care payment is risky, he said.

Medical Errors – Ms. Roberts and Fran Cadez prepared a 28-page medical errors study work plan and timeline. However, the next step in the study's evolutionary process is its presentation to the Legislature in October or November. It should be noted that the amount of time Ms. Cadez has under an agreement between the Department of Health and the Healthcare Commission to work on the medical errors project is limited; the Memorandum of Understanding between the two entities to share Ms. Cadez's time is set to run out in December.

Tobacco – Ms. Ladd said that on Oct. 6, the Department of Family Services and Department of Corrections will meet with the Commission and the Substance Abuse Prevention Division of the Department of Health to consider best options for investing tobacco settlement money in tobacco use prevention. Ms. Sapp has obtained definition of how tobacco use prevention is now being funded, Ms. Ladd said. Additional investment in tobacco use prevention has been recommended by the Commission. Department of Health Director Sherard noted that the Commission's interest in the expenditure of tobacco settlement funds will help preserve its use for tobacco use prevention activities; other states find their tobacco settlement dollars extracted for government programs unrelated to substance abuse.

Advance directives registry – Mr. Mossbrook said research he and WHCC staff conducted indicates that putting an advance directives icon on Wyoming driver's licenses and training emergency medical technicians to act on advance directives are not effective means of shifting the culture away from preserving life at any cost to honoring advance directives. Investigation of the potential for using the advance directives registry as a platform for a personal health record revealed that HIPAA complicates making the advance directives registry into a personal health record. While possible to make advance directives a platform for a continuity of care record, the start up would be far more costly and belabored. The work plan and time line for the advance directives registry now call for potentially pairing with another state for registry services. There will be discussion in the future regarding transferring the registry back to Wyoming and where it would be housed and operated. Marketing will occur partially in tandem with organizations already promoting advance directives, and will take place over many months, he said.

Clinical guidelines – Ms. Patarino reported that the work on clinical guidelines implementation for the state employee health plan is in a preliminary stage. She has discussed with Dr. Glode what the goals for clinical guidelines can be and what the

options are for implementation, which once analyzed can be put before the Commission to consider before recommendation of a clinical guidelines collaborative is acted upon. Dr. Glode said it is important to identify what the state wants to achieve with guidelines because sometimes the outcome is unexpected – costs may go up even though health is improved and the quality of care is better.

Health information technology – Ms.Genoff reported that the Wyoming Health Information Organization (WYHIO) has been formed and the electronic medical records study completed by John Snow, Inc., and the Health Information Technology Technical Management Subcommittee will be presented to the state Legislature in October. What role the Commission will play in the future of electronic medical records advancement will depend on the Legislature's decisions and information coming from Ms. Jenkins, who is serving as an ex-officio member of the WYHIO. Steve Chasson, a WYHIO Board member and director of the Wyoming Primary Care Association, will attend a multi-state health information technology meeting in Montana next week; the Commission will pay for his travel to assure that Wyoming is in tune with efforts to regionalize electronic medical records and share resources. The WYHIO's first Board meeting will be on Oct. 6, by telephone conference.

Provider database – Ms. Ladd said that this month a contract has been signed with the Health Professions Tracking Center in Nebraska and the first Wyoming medical professional surveys will go to physicians, physician assistants and nurse practitioners. An estimated 70 percent response is anticipated in the first round survey. Letters inviting participation the survey will be signed by key Wyoming state government officials to encourage healthcare practitioners to participate.

Consumer report cards – Ms. Ladd reported that in conversation with the Governor, he has advised moving cautiously on report cards to assure strong buy in and potential success. The draft work plan and timeline are based on coming to a "build or buy" decision, she said. There are consumer report cards on the market already and it may be possible for Wyoming to contract for data rather than building its own data collection, analysis and reporting program. The concerns regarding errors in the data collection and reporting fall on the shoulders of that entity rather than the state if a system is purchased rather than constructed, she said.

Quote of the day: "It was just gas"

September 26, 2005

Attendance:

T. Chris Muirhead, Chairman, George B. Bryce, Marlene Ethier, Jack Glode, M.D., Carol Jenkins, Lorraine Saulino-Klein, Steve Mossbrook, Dixie Roberts, John Vandel, Commissioners, Ken Vines, Insurance Commissioner, Dr. Brent Sherard, Department of Health, Ex-Officio, Julie Sapp, Governor's staff, Anne Ladd, Emily Genoff, Fran Cadez, Claire Brockbank and Michele Patarino, WHCC staff. Representatives of the public in

attendance were Beth Wasson, Steve Chasson, Lynn Birleffi, Jan Drury, Rick Rush, John Hastert, Michael Stelmach, Sheralyn Kaiser, Marcia Shanor, Bob Kidd, Paul Poister, and John McBride.

Meeting called to order by Chairman Muirhead.

Committee reports

Supply side -- Committee chair Steve Mossbrook reported that in the presentation of the provider database, advance directives and tobacco work plans and timelines on Sept. 25, the committee's work has been reviewed.

Demand side --Committee chair George Bryce met with Wyoming's congressional delegation staff recently and reviewed the challenges to implementing the WyoCare model under current federal restrictions. He noted that there is work nationally parallel to what is happening in Wyoming to increase access to healthcare coverage. WyoCare as envisioned in the "straw man" concept implementation description would streamline administration of insurance for the uninsured and consolidate funds from multiple sources into accounts usable for the purchase of coverage and care. The guiding principle of WyoCare is cost containment, not cost shifting. Mr. Bryce said that any system built under WyoCare needs to:

- reign in excess charges for medical procedures while being fair to providers,
- promote evidence-based medicine (total health management);
- make consumers responsible for their health,
- reduce administrative barriers to paying for care, and
- do nothing in the short term to hamper the provision of quality, accessible care at an affordable price.

Consultation with attorneys indicates a trust account is the best means of capturing and managing the funds collected from, and for, consumers to be invested in healthcare coverage in the small group market. The committee has been asked to look at other pool approaches under which there would be more state-controlled plans melded into the creation of a larger pool. State government has the capability of working on the uninsurance pool that WyoCare is working on, Mr. Bryce said. The opportunity to invest state dollars in consolidation of administrative costs might be preferable to creating WyoCare's operation independently, he said.

Rick Rush, Leif and Associates, on reinsurance and premium subsidy analysis

(Note: Mr. Rush's Powerpoint presentation available by email upon request or on the Wyoming Healthcare Commission web site, www.wyominghealthcarecommission.org)

Mr. Rush, an actuary, reported that Leif surveyed the five health insurance carriers in the state and obtained substantial claims data that will allow for the quantification of subsidy requirements to lower the cost of health insurance premiums. The information was gathered by Leif and Associates under a contract with the Healthcare Commission to attempt to anticipate how many employers and individuals would enroll in healthcare coverage if the premium rates were reduced.

The report Mr. Rush is compiling will educate the subcommittee working on WyoCare in the process to defining how to structure a program using state dollars to increase coverage alternatives in the private sector.

One means of subsidizing coverage for people who are employed but do not have insurance would be to reinsure high cost claims to reduce potentially premium costs. Leif and Associates' findings show that 20 percent of covered lives generate 76 percent of claims. The most costly 5 percent of the population analyzed generate 44 percent of claims. There are two reinsurance pools operating in the state currently; the small group reinsurance pool has little participation. Changing the small group reinsurance pool formula could increase risk to carriers but reduce assessments and premiums. The difficulties of projecting consumer claim histories prevent carriers from participating in the small group pool; a life ceded to the pool increases the assessments they pay. Discussion followed regarding reinsurance and why a state would be interested in buying that kind of coverage. Only about 15 states participate in reinsurance programs.

Mr. Rush reviewed alternative models of reinsuring high claims costs and findings from interviews with carriers operating in Wyoming regarding what would make a pool attractive to them. He detailed the potential impact of broader assessments and premium tax credits for all property, life and casualty firms, which has been proposed by state legislators in the past. Discussion followed regarding the reasons for shifting state insurance policy to collect funds from all insurers to reduce the cost of insuring the small group market's high claims.

Lynn Birleffi said the intention of past legislation was to capture dollars collected from insurance companies and put in the state's General Fund, and apply them back to provision of healthcare coverage rather than allowing them to be spent on any state government function. Discussion followed regarding the funding of the Insurance Department's operations. The Insurance Department is funded with an assessment of all insurance companies, Insurance Commissioner Ken Vines said, and all premium taxes go to the General Fund. In 2004, Wyoming collected $17.9 million in premium taxes that went into the General Fund, Mr. Rush said. A separate assessment is paid by insurance carriers, John McBride of Blue Cross Blue Shield said. About 1,100 insurance companies are licensed in Wyoming and they each paid about $1,700, totaling $3.7 million per biennium.

The Healthy New York program is a subsidized premium program model, Mr. Rush said. The state of New York operates the pool, there is a qualified listing of who is eligible for subsidized premiums, and there are no assessments for losses. Carriers set their own rates for the eligible population. In Arizona, a different kind of subsidized premium program model is operating. In that state, there is no guaranteed loss ratio – carriers participating in the program are to sell subsidized rates and are guaranteed by the state to achieve a certain margin. However, Arizona is withdrawing its support for that model, he said. It was found that the coverage was being purchased by people who were in a higher income group than the working poor. Most of those reached were older, self-employed business

people, Ms. Brockbank said. Ms. Jenkins said that has been the experience of many plans targeting the uninsured and must be considered in WyoCare's planning, she said. The Healthy New York program sets eligibility guidelines requiring that employers participating have a low-income workforce to qualify for subsidy, Mr. Rush said. Premiums initially fell 17 percent for that population, Ms. Brockbank said, and now are 35 percent below the open market. The program is run only through HMOs, however.

Literature review indicates that the take-up rate for 10 percent subsidized small employer premiums is about 3.5 percent, Mr. Rush said. A 10 percent increase in premiums results in less drop off of insured lives because once people are enrolled, they are not as price sensitive as people being enticed to enroll in the first place. Most of the uninsured do have a job with a small employer, in Wyoming, he said. A $10 million subsidy is predicted to reduce premiums by 10 percent, if carriers put 100 percent of that money back into their premiums, Mr. Rush said. However, the state would have to change its statutes to mandate putting those dollars into premium reductions. If the $10 million infusion is limited to benefiting small group employers who are not in the small group market now, there could be a 40 percent reduction in rates and the take up factor would be 6,500 new lives, he said.

The uninsured population in Wyoming is estimated to be around 80,000 lives; 15,000 are thought to be non-working and 65,000 of those people have jobs – 44,000 with small group employers (or self employed). Small group employers in Wyoming are defined as having two to 50 employees, but this dataset includes people who are self employed, according to Mr. Bryce, Ms. Brockbank and Mr. Rush. Insuring 4,600 people by subsidizing small group employers would reduce the number of uninsured by 6 percent and increase the small group market by 17 percent, Mr. Rush said. The marketplace will collect $13 million on those lives if those people are not currently paying anything for medical care, he said. The employer is contributing and the employee is contributing to the purchase of coverage, so the subsidy captures other dollars.

Mr. Rush detailed the assumptions behind his models regarding consumer and employer responses to cost reductions and increases in insurance premiums. Discussion followed regarding where growth would occur and why, within Wyoming's market. North Dakota has the lowest number of uninsured in the country at 7 percent, Mr. Bryce said. Reducing Wyoming's uninsured population by 6,500 lives is not enough, he said. The goal of WyoCare is to get uninsurance down by 50 percent. Free coverage isn't always taken, Mr. Rush pointed out. SCHIP is an example of that. Self funded, or ERISA, plans are not factored into the modeling, he said. ERISA plans are not regulated by the state, Mr. Vines said. Employers self fund to avoid premium taxes and state insurance laws.

Subsidizing premiums for individuals working for small employers who are not offered or eligible for coverage and individuals not aligned with an employer was presented by Mr. Rush as a means of reducing the number of uninsured in Wyoming. There are 30,000 insured individuals in the individual market and 27,000 in the small group market, today. He explained how the $10 million subsidy could be leveraged to bring in 8,300 lives. Discussion followed regarding eligibility and the means of controlling costs. The

individual marketplace isn't guarantee issue, Mr. McBride said, resulting in adverse selection potentially and the unhealthy would be attracted so the experience would be a greater loss ratio than what exists. Mr. Rush responded that the individual marketplace today has about a 50 percent approval rate for coverage; the 50 percent who are sicker do not qualify for coverage. If there are income eligibility restrictions to limit what is offered to those at 200 percent of the federal poverty level, the targeted population will be those people are not likely to be buying healthcare coverage. There are not many people at 200 percent of poverty who are able to afford insurance. One of the details that will have to be worked out concerns how the state's reinsured high risk pool works and what integration would be with the models he is working on. Discussion followed regarding what consumers and carriers can be expected to do under certain models' parameters.

To reduce uninsurance in Wyoming by 20 percent by offering the subsidy to individuals would take a 30 percent premium reduction and an $18 million subsidy, Mr. Rush said. Targeting only the small group would require a 50 percent subsidy to make a 20 percent reduction in uninsurance. What other states are doing was reviewed – Hawaii requires employers to provide healthcare coverage if they have more than 10 employees, but there are still people without insurance. Some states are requiring the reporting of employers who have a number of workers on Medicaid rolls.

Mr. Bryce explained that consideration should be given to the fact that WyoCare captures other dollars for premium purchase, including spouses, and consideration should be given to the potential for coverage of families rather than just individuals who are employed. Discussion followed regarding the potential for a healthcare coverage "hours bank" and the limitations that would be required to prevent people from going in and out of coverage when ill or injured. Other evidence supporting employer coverage is productivity of healthy workers, Lorraine Saulino-Klein noted. Reinsurance modeling should not be examined independent of other factors that impact healthcare delivery and medical costs.

> **Commissioners' comments:** Dr. Jack Glode said discussions have excluded 21,000 people who work for large employers and have no coverage. If one of the problems is cost shifting, it is no less significant for them but no discussion is heard regarding providing healthcare coverage for them. Discussion followed regarding who can be successfully targeted and what impact might be had on large employers who are self insured and not state regulated. Seventy two percent of employers said they were willing to contribute funding to coverage for part-time employees if accounts accumulating funds for the purchase of health insurance were allowable, Mr. Bryce said. Large employers could make contributions now for part time employees, however, through credits, Mr. Rush noted. He thinks they would be more willing to contribute a share if other large employers were able to contribute as well. Ms. Birleffi said before making conclusions about large hotels and retailers, interviews should be conducted with them to find out what they are offering to part time workers. There is a group of people who work marginally. The effort should be made to preserve the small group market before focusing on the large group and their part time workers.

Comments from the pubic: Mr. McBride said Sen. Scott has a reinsurance bill in hand that was drafted by former Sen. Cale Case as a credit against premium tax for all insurers offering coverage in Wyoming. Ms. Ladd said Sen. Scott has gotten Mr. Rush's report and will be getting a steady flow of actuarial information from the Commission. Mr. Rush has been made available to the Labor, Health and Social Services Committee he co-chairs with Rep. Doug Osborn.

Medical Errors -- Ms. Roberts and Ms. Cadez reported the corrections and changes requested in the medical errors study report earlier in the month on a conference call review of the report are contained in the document. Changes recommended by Dr. Michelle Mello of Harvard will be added prior to the report's release, amending the document's structure but not its content.

A Wyoming commission is recommended to gather the input of stakeholders in the state, Ms. Roberts said. There is potential for Wyoming to join a national data collaborative; the experiences of Wyoming's hospitals may provide too little scale for trending, Mr. Mossbrook suggested. Dr. Glode said an example of that is a national collaborative for cath lab reporting. Small cath labs with few cases per year are compared in a blind sample with a national subset of small, similar providers. The independent commission recommended, however, would be Wyoming based and Wyoming specific, Dr. Glode said.

Discussion followed regarding the errors reporting culture variations within facilities and the current system's inability to use error information to result in systemic change. The recommendations of the report are intended to change the way the medical care delivery system reveals what transpires in the performance of procedures and how that information is analyzed to result in changes in practices, Ms. Roberts and Ms. Cadez said.

Most peer review and credentialing committees use anecdotal information to make decisions, Dr. Glode said. "It is hard to disenfranchise a physician, no matter what their track record is," he said. Ms. Roberts said there are economic incentives for eliminating medical errors and yet there is a monumental resistance to change. Ms. Jenkins noted that anesthesiologists' Patient Safety Foundation (created 20 years ago) has reduced medical malpractice insurance rates. She wondered why that model has not been replicated by other specialties. Dr. Glode said it was easier for anesthesiologists to band together for change because they are smaller in number and limited in scope. The resistance in other high-risk specialties is likely to diminish as premiums continue to go up for medical malpractice coverage, he predicted. "Hopefully we can do it better through a systems approach that is global and not specific to one specialty," Dr. Glode said.

Mr. Mossbrook questioned linking electronic medical records and medical errors. Two Commissions are needed, one addressing errors and the other working on electronic medical records, Mr. Mossbrook said. One of the problems with tracking records is the absence of electronic medical records, Dr. Glode said. If the Wyoming Health Information Organization adopts and implements the infrastructure for electronic health

records, the state could be asked to track specific issues not part of the national health records but the WYHIO would be independent.

Dr. Sherard asked if medical errors systems have been successful in states without meaningful tort reform. He thinks he knows why physicians don't report errors, although it is important for patient safety: physicians fear being sued. Ms. Cadez said there was no analysis of tort reform in tandem with errors reporting systems; nationally, the two are independent and the literature maintains that separation.

Mr. Bryce asked whether the Commission's assignment to address medical errors in Wyoming is complete with the submission of the committee's report to the Legislature. Mr. Muirhead said the Commission's budget includes money for developing recommendations contained in the report. Ms. Ladd said the Governor and his staff indicated in discussions last week that commissions do not traditionally request funding for implementation of strategies recommended. Whether the Commission waits for specific legislative recommendation or acts without one is unclear, she said.

Ms. Roberts said part of her committee's strategy was to focus on the areas of medical errors intervention that are doable, even though the legislative mandate was broad and incorporated avenues that would take decades to map. The goal of the committee's work was to prevent the Legislature from coming up with a laundry list of strategies that are not feasible in the current time, she said.

Discussion followed regarding the process for Commission implementation of strategies. Dr. Glode said that with the budget submitted recently to the Governor's Office, the Commission has ceased to be a "study and recommend group," particularly since the Commission is requesting money to develop a product and run a business in the vision for WyoCare.

Mr. Mossbrook moved to accept the report and Ms. Roberts supported it; Ms. Saulino-Klein seconded. The motion passed unanimously. The study will be posted on the Commission's web site and mailed to the Labor, Health and Social Services Committee on or before Oct. 1, 2005.

Nursing workforce -- Ms. Ethier asked the Commission to consider supporting a study proposed by the Wyoming Board of Nursing and Department of Employment. The Health Professions Tracking Center data base development the Commission is contracting for does not include nurse tracking. The Department of Employment has done nursing workforce research in the past. The Board of Nursing is interested in studying why nurses do not stay employed in their profession in Wyoming. The study proposed would place a nurse in the Board of Nursing office to analyze data collected by the Department of Employment Research and Planning section. The total cost projected is $274,473, to be funded with a General Fund appropriation if approved.

Ms. Sapp proposed changes to the wording in the proposal. Funding for the Board of Nursing is difficult to get because as a licensing entity, it can charge fees and legislators

believe fees can be hiked to cover additional Board costs, Mr. Vandel and Ms. Ethier said. Dr. Sherard said that the Department of Health funds Wyoming Health Resources Network (WHRN) to recruit and retain health but nursing retention, recruiting and tracking has not been part of what the Department of Health pays for, he said. Ms. Ethier said it is hoped that when the Commission's contract with the Health Professions Tracking Center in Nebraska expands to include other health professionals, nurses can be incorporated and the position will not be needed in the Board of Nursing after that time.

Discussion followed regarding whether it would make sense to fund the Health Professions Tracking Center's expansion into nurse tracking now or to start with the Board of Nursing study as proposed, for about the same cost. The Nebraska-based Health Professions Tracking Center has not surveyed nurses in the past and it would be costly to develop data showing the employment patterns of the estimated 13,000 licensed nursing professionals (including nurse practitioners and certified nursing assistants) in Wyoming, Ms. Ladd and Ms. Ethier said.

The Department of Employment has experience and Memoranda of Understanding needed to access nursing professional records successfully, Ms. Ethier said. Nursing program enrollment has expanded in Wyoming but if those recent graduates leave the state to work, the cost of that has not benefited patients here, she said. The opportunity is being presented by the study proposal to look at why nursing professionals will not stay in the profession and the state, Ms. Ethier said. The study is less about quantifying the nurses' numbers and more about determining their working conditions, Mr. Muirhead said.

Ms. Saulino-Klein encouraged the Commission to support the letter. Mr. Bryce questioned why the Department of Employment needs an additional $130,000. Ms. Ladd and Ms. Ethier will work on the wording of the letter that will be forwarded from the Commission to the Legislature in support of the study proposal and requested funding.

Information Technology Technical Management -- Michael Stelmach of John Snow, Inc. (JSI), the consultant conducting Wyoming's electronic health records study completed this month, reviewed the study's highlights for the Commission. Dr. Geoffrey Smith, Chairman of the Health Information Technology Technical Management Committee and the recently-formed, Commission-recommended Wyoming Health Information Organization (WYHIO) will present his groups' work to the Joint Labor, Health and Social Services Committee in Casper on Oct. 17.

Mr. Stelmach said the report's message in simplest terms is that the road to a statewide network has four wheels: enable (enabling technology), share (a centralized network of services), promote (focused initiatives) and manage (a technology support organization) health information. First, a regional health information organization should be formed – and in fact, a Wyoming Health Information Organization (WYHIO) was created in August. The WYHIO will choose standards and guidelines for electronic health records technology and information sharing. Dissemination of electronic health record technology and use in physician offices and hospitals is proposed simultaneously with

development of a “network hub” that will collect and integrate information filtered through WYHIO-applied standards and guidelines.

Discussion followed regarding the investment of millions of dollars in a Wyoming-based electronic health record network that might be stalled or redirected by federal guidelines or standards now unfolding at a rapid pace. Mr. Stelmach said the network hub would be adaptable to a variety of messaging standards. When electronic medical record vendors are engaged, the requirement would be that they integrate with the hub – that minimizes the variables, he said. He predicted that vendors will be aggressive because of the potential to launch the Wyoming network as a national model and for substantial additional business. JSI was “elated” when learning it had won the Wyoming electronic medical records study contract, Mr. Stelmach said.

Dr. Smith said that the $48 million proposed in the electronic health records study for hospitals is not unrealistic given the experience he has had in his diagnostic radiology practice in Casper with integration of different data sets. In looking at statewide integration and the permutations of data links, the hub and scope architecture becomes particularly compelling and expensive in the front end but worthwhile in the longer term, Dr. Smith said. The compelling reason to be integrated into the network will have to be a service -- administrative transaction processing service or ePrescribing, for example, as proposed in the study plan, Mr. Stelmach noted.

The hospital cost estimate could be lower if all the hospitals that are prepared for and working toward electronic medical records implementation are in the first phase of the plan and hospitals deemed less ready are dropped, Mr. Stelmach said. The cost proposal attached to the plan is high because some hospitals that are not ready for health information technology are incorporated into the estimate. Removing them reduces the cost by as much as $25 million, he said.

When the Wyoming network is built as envisioned, it can accommodate new services and tighter integration and reach the goal of an interoperable health network, unprecedented in the nation. Government subsidy will incentivized hospital and physician investment in electronic medical records technology, Mr. Stelmach said. Dr. Glode said the physician group he worked with invested a large amount of money in an in-house system that may not keep up with standards as they unfold in the state and nationally. For smaller practices and particularly with subsidy, the only way to get hooked up to electronic medical records systems is to adopt what is being promoted by the WYHIO, he said.

The study presents alternatives for phasing in the plan and finding funding for projects and processes. Mr. Mossbrook asked when, where and how the physicians and hospitals not in the early phases are incorporated into the network when several million are dollars are proposed to be going out the door annually for the initial groups’ annual support. The proposed $77 million is step one and the other steps are not quantified.

Mr. Stelmach said that if at the end of year five, the claims administration, e-prescribing, patient health summary components of the plan and the hub are fully implemented, there

will be compelling success stories to provide a foundation for statewide adoption of the electronic health records network. The roadmap will be in place to get the rest on board and the cost will be significantly reduced to add hospitals and providers, he said. His experience in Wyoming is that the state is positioned to act faster and at a higher level than others, Mr. Stelmach said. The key to long term success is investing in the hub, up front, he emphasized. Mr. Muirhead said the state puts $3 billion a year into healthcare, so the investment required in the plan is really a "drop in the bucket."

Mr. Muirhead asked whether the Commission was ready to send the document on. Ms. Sapp asked if the Commission is going to make the wholesale $77 million recommendation in the plan or different routes to take that cost less and can be done in pieces. Mr. Mossbrook said if the 12 most technologically advanced hospitals and 233 most advanced practices in the state and rewarded them with subsidized network system integration, they will make the most use of the advancements the fastest. Mr. Stelmach presented a spreadsheet what shows what costs can be shifted.

Ms. Sapp the Commission can recommend a path within the report that contains "the most bang for the buck." A wholesale, $77 million recommendation will be sunk, she said. Mr. Mossbrook said that politically there may be advantages to including investment of electronic medical records installation dollars rural providers that are not prepared to fully utilize the technology, but it would make more sense to have 12 legacy hospitals set up first with state subsidy.

Mr. Stelmach said $38 million would be saved and the feasibility exponentially increased if only the best prepared hospitals and physicians are included initially in the plan. The Commission discussed the need for superimposing the model for electronic medical records dissemination chosen over a map of the state's demographics and healthcare delivery system.

Ms. Roberts said if the hospitals already situated for electronic health records and information sharing are the focus of subsidies, the Commission is not giving the money to providers outright – rewards are being given to providers who have already invested in advancing health information systems. Discussion followed regarding the use of data obtained from Dr. Hank Gardner showing referral patterns. Casper, Cheyenne, Jackson, Gillette, maybe Laramie and Sheridan might be the hospitals and communities best targeted, Commissioners said. Mr. Muirhead asked Wyoming Hospital Association President Bob Kidd whether he had any comment but he said he was just listening. Dr. Sherard was asked whether the Department of Health could facilitate or fund loans to physicians and hospitals implementing electronic health records systems with state subsidy. He said that although new money would have to be allocated by the Legislature to loan out, the Department has the means of distributing and collecting loaned dollars.

A Wyoming-based "technical support organization" will lower electronic medical records installation and operation costs over time. The careful upfront construction of the hub used to share electronic medical records' contents will assure long term success, Mr. Stelmach said. Ms. Roberts said supporting investment of $4 million in the hub and

matching grants or other cash incentives for implementation of electronic medical records by hospitals and physicians determined to be eligible based on readiness might be a solid recommendation to the Legislature. Dr. Glode said some physicians might be willing to invest their money if benefit from the installation of electronic medical records can be demonstrated. Cost effectiveness will have to be defended to people who may not have a good understanding of health information technology's assets, Dr. Glode said. Physicians are skeptical because of the cost, he said.

Mr. Muirhead said he does not see the WYHIO being operable soon enough to made recommendations. The Commission is not prepared today to give solid direction to policymakers on how to most wisely invest in electronic medical records, or how much money should be spent initially, he said. The Legislature will get recommendations on Oct. 15 as required by the statute mandating the electronic health records study. In the meantime, the Commission can accept and issue the report being reviewed today as is and make a recommendation later, or wait to issue the report until a recommendation is formulated. Ms. Roberts, Mr. Mossbrook, Ms. Jenkins and Dr. Glode were asked to serve on the committee. Ms. Roberts will chair.

Mr. Mossbrook asked that the hospitals determined to be "legacy" level be revealed to the newly-formed committee, and a working version of the "plug and play" financial model be immediately available from JSI for working through different cost equations. The Commission will have a conference call around Oct. 10, Mr. Muirhead said, at which time a more specific recommendation for electronic health records investment will be reviewed that has taken into the consideration and refined the work done by JSI and the IT2. Dr. Smith will be asked to participate.

Mr. Stelmach said he recommends the following priorities: engaging physicians and hospitals most capable of using electronic medical records, building the hub, creating the technical support organization and launching the four services (ePrescribing, administrative transactions, etc.). Together, those priorities could cost less than $35 million depending on which hospitals are involved, he said.

Ms. Sapp said that in front of the Joint Labor, Health and Social Services Committee, the presentation will need to emphasize the recommendations for electronic health records implementation in Wyoming. If the legislators are being asked to delve too deeply into a large document, little response can be anticipated.

The more buy in demonstrated by providers, the more politically palatable an electronic medical records system will be, particularly when the money is going to physicians who are among the wealthy in the state, Ms. Roberts and Ms. Sapp said. Ms. Ladd said the underlying question, when the investment is considered, is whether electronic medical records are of greatest potential benefit to patients, or physicians? She said that the business case for electronic medical records is difficult to make and may in fact be a negative case. The benefit accrues to the payors or the public at large, she said. Mr. Stelmach said that there is a study that showed physicians would have to be reimbursed $3 to $4 per patient visit to justify installing electronic medical records technology in

their practices. Dr. Glode said that there are primary care physicians who are stressed financially and cannot afford electronic health records, even though physicians are considered wealthy. Implementation costs docs three to four patients today because productivity slows down significantly initially, he said.

Partnership for Prescription Assistance

Paul Poister of the Partnership for Prescription Assistance (PPA) said that his organization is operating in Wyoming and is available for promotion to consumers. The partnership is a web portal targeting consumers to help them identify whether there is assistance available with getting prescription medications at reduced or no cost. Patient advocacy groups are helping to spread the word about the PPA in the state.

Eligibility varies, Mr. Poister said, for assistance with the purchase of prescription drugs. Income of no more than 200 percent of the federal poverty level is a basis for eligibility. If a person has healthcare coverage, including Medicaid, with prescription medications included, the opportunities for assistance are limited. There is a link to the PPA on the Wyoming Department of Health web site. Ms. Sapp said she has referred people to the PPA. Mr. Vandel said only 10 percent to 15 percent of Wyoming's population is going to be eligible since most are enrolled in some sort of public or private healthcare coverage program. There are about 47,000 people in the state who can take advantage of the programs offered on the site, Mr. Poister said.

Subcommittee structure for 2005-06

Mr. Muirhead said in order to work through the details in each of the work plans, new committees have been formed to address each priority subject and will come back with realistic visions for implementation:

Committee	Members	Staff
WyoCare and State Employees Benefit Plan	*George Bryce* *Carol Jenkins* *John Vandel* *Ken Vines*	Claire Brockbank
Medical Errors	*Dixie Roberts* *Jack Glode*	Fran Cadez
Tobacco	*Carol Jenkins* *Lorraine Saulino-Klein*	Michele Patarino
WyHIO	*Carol Jenkins*	Emily Genoff
Advance Care Directives Registry	*Steve Mossbrook* *Brent Sherard, M.D.*	Emily
Clinical Guidelines	*Marlene Ethier* *Jack Glode, M.D.* *Brent Sherard, M.D.* *John Vandel*	Michele
Healthcare Consumer Reports	*T. Chris Muirhead* *Dixie Roberts* *Jack Speight* *Lorraine Saulino-Klein*	Anne
Provider Inventory	*Steve Mossbrook* *Marlene Ethier* *Brent Sherard, M.D.*	Anne

The charge of each new committee will be to begin working immediately to do what is necessary to formulate well-founded work plans, Mr. Muirhead said. Reports are due from each committee at the next Commission meeting in Cheyenne at the Hitching Post Inn on Oct. 23-24. Discussion followed regarding the priorities and the process for piecing recommendations together. “I want to focus the next nine months on hitting these seven items,” Mr. Muirhead said, referring to the Commission’s priorities. Subcommittees have a responsibility to bring commissioners not participating in their work up to speed each month, he said.

Dr. Glode expressed concern about the tight timelines that the Commission is required to work under. He said there are pitfalls and controversies to be avoided if greater periods of analysis are allowed. Discussion followed regarding the priorities selected by the Commission. Once decisions are made by the Commission about a specific issue or healthcare delivery system strategy, the commissioners need to stand in lock step, Mr. Muirhead said.

Public comment

Steve Chasson asked if there is going to be public involvement in the new committees. Mr. Muirhead said members of the public can be asked to serve on committees and they can be reimbursed for travel.

Quote of the day: “We don’t know what we don’t know.”