

Healthcare Coverage Reform Initiative

Advisory Committee (AC) Meeting Minutes

Tuesday, October 30, 2007

9:00 a.m. to noon & 1:00-4:00 p.m.

Lazarus Government Center, Room C621 A&B, 6th Floor
Ohio Department of Job & Family Services (ODJFS)
50 W. Town Street, Columbus, OH 43215

Attendees:

Brent Mulgrew, Jerry Friedman, Ken Statz, Toya Johnson, Cynthia Burnell, Carol Roe, Brian Keaton, Deborah Miller, Teresa Long, Elise Geig, Steve Millard, Joe Gibbons, Ty Pine, Roger Geiger, Jessica Hart, Jim Castle, TC Wolfe, Jon Fishpaw, Tamiyka Kogel, Fred McGraw, Heath MacAlpine, Linda Woggon, William Fitzgibbon, Kelly McGivern, Nancy Enright, Tom Latkovic, Dave Dorsky, Derek Bridges, Chris Whistler, Sen. Shirley Smith, Kathleen Gmeiner, Vuka Stricevic, George Dunigan, Holly Saelens, Amy Goldstein, Nick Lashutka, Dave Dillon, Margie Frazier, Jessie Cannon, Col Owens, Ron Bridges, Ted Fisher, Cathy Levine, Marianne Steger, John Burant, Juke DiRossi, Gregory Myers, Michelle Fitzgibbon, Bill Hayes, Katherine Kuck, Robbin Harris, Cristal Thomas, Rep. Jim Raussen, Doug Anderson, Mary Jo Hudson, Malika Bartlett, Carly Glick, Kevin Tyler, Marjorie Ellis, Suparna Bhaskaran.

1. Introductions and welcome by Doug Anderson from the Ohio Department of Insurance. Doug introduced Steve Wall who would be the facilitator for the day. Steve underscored the ground rules for discussions and went over instructions for successful group work. Doug informed the Advisory Committee that the AM and PM session would involve break out groups with specific questions. And, that after the lunch break Dave Dillon will speak to the Advisory Committee.
2. Doug updated the Advisory Committee on the key issues discussed at the October 19 SCI meeting. First, the SCI Team looked at the synthesis of the information gathered from the October 9 Advisory Committee small-group question: "Reforms need to work for what uninsured populations, and why?" The summary identified (1) vulnerable individuals and (2) employer groups (provided to the SCI team as a handout). From this handout the SCI Team asked if vulnerable individuals could be further condensed and categorized in terms of (1) employment status (2) health status (3) income status. DA: Tim at the HPIO put together charts and Bill will discuss them with you. The overlaps between the three categories will cover many others.
3. Bill Hayes provided numbers for these three categories and provided the Advisory Committee with two charts to identify which 500,000 Ohioans must be insured. The first chart was "Uninsured Ohioans By Income, Health and Work Status

(2007 Expected Estimates).” The second chart was “Uninsured Ohioans By Income, Health and Work Status (2004 Firm Size Breakouts, 2007 Estimated Totals).” Estimates for these calculations were derived using the 2004 Ohio Family Health Survey as a base and the 2006 and 2007 Ohio Health Issues Polls and the 2004-06 Current Population Survey’s March Supplements as weighting data to project 2007 uninsured statistics. A comment was made that it would be important to look at healthy populations often lost in the term “single.” They include vulnerable individuals such as domestic partners and stay at home parents (including the unmarried & unemployed). *What will be the process to determine what level of poverty will get benefits?* It was determined that we could easily get these guidelines. Doug mentioned that 100%, 300% were all being considered. Other comments included: the need to determine what benefits will be offered because that will help determine who is covered; the need to talk about scope of coverage. DA: this is part of the agenda for the next meeting; and the need to also consider both the undocumented population and documented immigrants (permanent residents) who do not qualify for benefits such as Medicaid in Ohio.

4. Steve Wall asks Advisory Committee to get into their small groups and members are assigned their groups. The two questions are: (1) Which 500,000 uninsured Ohioans do you want to make sure are covered by any reform effort? (2) What reforms do you think are capable of covering the 500, 000 people you identified? See small group responses in the back. These responses are reported back to the larger group by a member of the small group.
5. Lunch, noon to 1 p.m.
6. Dave Dillon is introduced by Doug Anderson and adds that the RFP is on the DAS website. DD introduces himself, his company and his project in relation to the Healthcare Initiative. DD: you give me five approaches and what we give you is the following: models, projections, costs, consequences; we have placed formal data requests from HMOs, insurers, Medicaid, individual and small group insurance market; we will assist you with plan designs and costs; and with your principles identify sustainable, affordable and preventative approaches; we will put a price tag on your choices; Ken Thorpe will assist us and he will address issues such as: who will it benefit and not benefit, the cost of OH and other parties. *How do you measure costs? What do you do with benefits analysis?* DD: As a reference point of cost we look at Medicare. We will look at per member per month cost. *What about sensitivity testing? How different should the reform models be?* DD: We will run 100, 000 scenarios regardless of overlap. You need to give us reference states we do sensitivity tests for all. *What are the pricing points of people taking up insurance?* DD: \$150/member/month is a good point for take up—middle working class. *How many numbers of options are possible?* DD: Make the major decision points and many other minor ones can be discovered along the way. *How did TN go?* DD: TN decided with the voluntary approach (Cover TN and Access TN for their high risk pool). MA has a much more heavily regulated market versus TN or OH. *How is TN working?* DD: Too

new to tell. *What's your end product?* DD: Give you approach type/reform pack and what has to be done to get there. We will give you answers to other specifics that apply to all packages. *Can you talk about utilization by income?* DD: Yes, we will illustrate for each group. *How far down will you see improvements in health?* DD: Ken Thorpe will model this. You will see this 3-5 years down the road. But opinions vary about this issue. We will also look at what if you do nothing, in addition to the MA, NY, TN models. *What about mechanisms for financing?* DD: We will not look at that. Risk is our focus; not the funding.

7. Advisory Committee is asked to break out into small groups. Steve Wall and his assistants have prepared a list of reform items to vote on with the intent to address these two questions: (1) What comprehensive reforms capable of covering 500,00- uninsured Ohioans by 2011 do you want to see modeled? (2) What elements of reforms do you want to see in any reform package? Designated members report back results to the larger group. See final results and any additional comments by small group members in the back.

8. Meeting adjourned at 4:00 p.m.

Italicized text indicates question/comment raised by group members.

Small Group Results: AM

Group 4

Priority Populations:

Good to excellent Health
Do not exclude Fair to Poor
200% FPL and Healthy (employed by SB)
Easy people?
Issue with picking 500K
Employed People (PT/FT/Seasonal/etc)
Pregnant Women—after birth
Independent contractors

Reforms:

Medicaid expansion 100% FPL and below (200,000)
Portability
Guaranteed Issue must be done with individual mandate
Small group pooling (small market insurance reforms)
Voluntary or involuntary?
Pool individual market and small group market?
Choice/Plan optional
Individual mandate for employed population
High Risk pool
Risk Adjusted Premiums

Group 3

Which 500, 000 uninsured Ohioans?

Are there people in the sick columns that are restorable to the good health column?
Universal access is important; uniform coverage?
Should everybody in exchange have uniform benefit packages? Everyone should have affordable access.
Good to see a mix of health status in the handout
Form a good risk pool—to spread out cost, risk
Blend risk
Need preventative health care programs and manage chronically ill populations
Question regarding the survey: Do people generally self-report as healthy?
What are our principles?
What ever we build we should be able to build upon a foundation for universal access and target populations. Follow principles of fairness, prevention health improvement
Disparities occur even when coverage is there
Need to find information on Starbucks and Meijer

What Reforms are capable of covering the 500,000 you identified?

Subsidy reforms needed

Benefit plan reforms

Market (insurance) reforms

What are the mechanisms? What are the principles?

State employee's plan; that is portable; guaranteed issue

Not sure if it is useful to merge small business and individual market

Look carefully at ratings

Group 2

How

Mandate-Individual

Tax Incentives-ER/EE

125 Accounts

Catastrophic Reinsurance (Healthy NY)

Insurance Reform: community rating; combine insured market

Broad based cost sharing: assessments; ERISA; premium; premium tax

Limit state mandates

Limit admin cost

Incentive, Outcome based plans

Concerns

Need to determine costs prior to choice

How to get young healthy insured?

Not reforming the healthcare system, looking only for ways to cover individuals

The 500,000

A. Medicaid eligible NOT enrolled

84, 00 adults

130, 000 kids

9,000 pregnant

Total: 223, 000

B. P/F, below 300% FPL, to small firms⇒ 190, 000

to medium firms⇒ 200,000

C. P/F, 300% FPL, to small firms⇒ 24, 000

To med firms⇒27,000

D. G/E, below FPL, to small firms⇒180, 000

Group 1

Cover people already eligible

Lower income, not working, poor to fair health status

- capture below 100%/200%
- amend eligibility requirements
- preventative care (those with good health)
- retain current resources

Incent small business owners to offer insurance
Expand purchasing power of connector by bringing in small business
Connectors with underlying insurance reform
Reinsurance (NY model)

High Risk Pool
Merge small and individual markets?
--community rating
Tie insurance to employment—sustainability
Circumstances vs. categories
Maximize utilization of employer-sponsored healthcare
Maximize federal Medicaid dollars
Portability

Health Status
Those in good health in the pool (health maintenance/manage risk)
10/90 poor health/chronic disease management
If had to drop one: drop those in good health

State employees/pension system—another pool
Subsidies—low-income folks
Direct Contracting

Parking Lot

Immigrants: (1) with documentation and (2) undocumented
Correct stats for work related
Conventional wisdom—80% uninsured; working/family working
Investigate
Estimates in each category
Expand domestic partnerships (vulnerable group)
What process will be used to determine % of FPL?
Target Specific 500,000 or Design a system for all and assume increased coverage
What is a reasonable % of income that should be required for health care?
Fair to reduce double counting?
Move away from risk grading individuals
Mandatory? Has admin. Changed mind? Chicago recommended it.

Small Group Results (PM) attached as chart.