HEALTH INSURANCE COST REDUCTION WORKING GROUP

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COMMISSIONER OF INSURANCE

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P R O C E E D I N G S

INSURANCE COMMISSIONER VOSS: I just really appreciate you all being here today. As you know, we are required under Senate File 2201 to convene a group to look at ways to reduce the cost of providing health insurance and health care services.

Let me just tell you a little background in case you don't know why this subsection came out. At the time there were a lot of concerns about insurance premium rate increases. During succession last year I had had a conversation with Representative Janet Petersen, who heads up the House Commerce Committee, and she was just very concerned about what she thought might be ancillary costs that didn't really apply to the underlying health care benefits that were provided in health insurance and health care.

We were just sort of having this free form discussion about well, you know, maybe there are things we can look at. We can certainly look at credentialing and uniform small employer applications. And there may be ways that--everybody is talking about e-records and technology, and that sort of thing--maybe there's a way to really look at those things.

And voila, now we have a study that we're

supposed to do on an annual basis due with our report on November 15th.

It doesn't really--you know, there's no drop dead as far as we must find certain things, we're supposed to make recommendations. We don't really have to solve the problem, we just have to make some recommendations.

I thought--what I have on this agenda is really just a brief list of things that are not only mentioned in Senate File 2201, but also some other ideas that came up, and maybe you have some other thoughts about cost drivers.

Today is really an open discussion, kind of let's throw things at the wall. We can go back to staff, Angel Robinson is here, who is our consumer advocate, and other people. What are some ideas that you think might assist.

We're not looking at ways to look at utilization or best practices on medical treatments, and that sort of thing. We're looking at sort of some of these maybe more administrative types of cost drivers that we can look at as ways to maybe reduce some of the administrative costs that we're all concerned about.

I don't know if we're going to have any

future meetings, it just kind of depends on what comes out today. Maybe the best thing to do is put your discussion thoughts together, we'll do some research on things you come up with, and maybe send out an e-mail.

Today we have a court reporter just because that way we can get all of your thoughts down and we won't miss anything. It's better than just having a note taker.

I thought it might be helpful because we have some people in the room that don't necessarily always come to our health care meetings directly, so if we can just go around the room and introduce yourselves. And if you have any thoughts or comments you want to present to the group initially, I would really appreciate it.

I guess we'll start over here with Joe.

MR. TEELING: Joe Teeling, and I'm invited, I guess, because I'm an insurance broker and representative of Health Underwriters, also small businesses, of which I have one. Thanks for inviting me. I have no comments at the moment.

MS. STROUSE: Marcie Strouse. I'm the president of Health Underwriters in the state right now, and I'm also an insurance broker.

MR. BOATTENHAMER: Greg Boattenhamer, Iowa Hospital Association.

INSURANCE COMMISSIONER VOSS: You don't have any thoughts, Greg?

MR. BOATTENHAMER: I have a few thoughts, but I think they're going to match up with yours.

MS. ROBINSON: Angel Robinson, Insurance Division Consumer Advocate. I look forward to working with you all.

MR. ALGER: Tom Alger with the Insurance Division, both the communications director and legislative liaison.

MR. GILLILAND: John Gilliland with the Iowa Association of Business and Industry.

MR. SKOW: Bob Skow with the Independent Insurance Agents of Iowa Association.

MS. KINZEL: Anne Kinzel, Iowa Legislative Health Care Coverage Commission.

DR. BURNHAM: Fred Burnham. I'm a dentist from Bettendorf representing the IDA.

MR. SUNDSTRUM: Scott Sundstrom, with the Federation of Iowa Insurers, S-U-N-D-S-T-R-O-M.

MS. DIERENFELD: Paula Dierenfeld, also with the Federation of Iowa Insurers.

DR. REITER: Dr. Peter Reiter, I'm a general

intern from Ottumwa. I'm here helping represent the Iowa Medical Society.

MS. FREEMAN: Jeanine Freeman with the Iowa Medical Society.

MS. NELSON: Sandy Nelson, Iowa Medical Society.

MS. GOERTZ: Christine Goertz, I'm representing the Iowa Chiropractic Society. My background is in, I'm a Doctor of Chiropractic, and also a scientist interested in health services and research and health policy.

MR. GARRETT: Dan Garrett from the Iowa Chiropractic Society also.

INSURANCE COMMISSIONER VOSS: Thank you all for coming.

Along with the agenda today I did make copies of the exact language, which, as I just mentioned, it was just kind of a preform discussion that we had with Representative Petersen about some of the underlying costs for this report in November.

I just think one other thing I will kind of mention is many times throughout the year we get contacts from provider groups, especially about frustrations about some things like undue paperwork. I know we're working towards e-records. A lot of

what was sort of in the thought process of this is times that our office has met with the medical society, chiropractors, about credentialing, or agents, and employers, such as ABI, about can't you just have one small employer application, one-size fits all.

I think one of the things that also came out from the discussion with Representative Petersen was is there any way we can cut down on all of the paper that enrollees receive on a regular basis. As an example, do I need to get a paper EOB every time I access services. Can't I just check a little box that says I agree to accept all my EOBs electronically on a quarterly basis. Things like that that I'm not sure how much they really reduce the cost, but this may be a way to look at convenience as well as cost drivers.

This is kind of the background of what happened. And as I said, I don't think they're expecting any major, we're going to cut health care by 10 percent, but I think it's a way to look at ways we can work closer together.

What I've listed there on the agenda, kind of basically A through F, are sort of a compilation of what's in the statute, but also through

discussions. Rather than just--I would kind of like to open it up and hear what you have to say about any of these, or what you perceive as maybe administrative barriers or ways that maybe we can help make the whole system a little more user friendly, cut down on some unnecessary paper. I know we've tried very hard to work on credentialing in the small employer uniform application.

Thank you. I hope everybody has filled out this, how we can get ahold of you.

I'm just going to open it up to anybody that has any thoughts about some of these suggested areas of concern or costs that we can deal with.

Dan.

MR. GARRETT: One question or one comment, I didn't hear if anyone is here representing an actual insurance company. Did somebody mention--

INSURANCE COMMISSIONER VOSS: We've got Paula and Scott here from the Federation.

MR. GARRETT: One question, and it sort of ties into federal health care reform, a lot of the federal health care reform that has come out speaks very specifically about wellness care and addresses lots of prevention types of things with the understanding, or the general understanding that

that's going to bring some costs down as it relates to long-term cost impact.

I'm just curious to know, you know, how that could be played out here in this work group to look at, you know, looking at an insurance company in Iowa that might drill down a little further on that issue and do sort of a pilot to bring that to the table.

I don't know. Just a thought.

INSURANCE COMMISSIONER VOSS: Yeah.

MR. GARRETT: I think it's a pretty squishy area, actually.

INSURANCE COMMISSIONER VOSS: Wellness and sort of prevention services. I know that we also have another study that we have to do on a yearly basis, the Division has, which is looking at the actual cost drivers of health care. And we're just in the process of, perhaps, hiring somebody to do the initial 2010 study, which is to look at what's driving health care costs up, or what are the drivers that are going down, or where are we saving money. That may be sort of--

MR. GARRETT: That could play into that. I sort of read that that's sort of part of this, too.

INSURANCE COMMISSIONER VOSS: Right. We will have to do that on an annual basis as well.

That will be more of an academic study for legislators to understand what are the actual cost drivers so that when they come in to make possible changes legislatively they can understand whatever they are doing may be affecting costs or types of treatment. What are the underlying drivers of health care.

DR. REITER: Whose costs are we caring about?

INSURANCE COMMISSIONER VOSS: In this?

DR. REITER: Yeah.

INSURANCE COMMISSIONER VOSS: It can be anybody.

DR. REITER: Most often overhead costs for insurance companies, or cost of patients, are what are discussed. There are a lot of costs to providers that are usually unspoken, many of which are driven up by policies, again, by the insurers that control their costs.

For example, all of the precertification requirements for imaging studies that have been put in place by Wellmark, and others. I think United and Wellmark are the two biggest ones right now.

INSURANCE COMMISSIONER VOSS: For imaging studies?

DR. REITER: Imaging studies. It takes our people, in aggregate, hours to do that each week, most of which are approved. In fact, I don't know of any that have been turned down of mine personally. It's a very inefficient system for our people. Generally they can't talk to a human being, it's a telephone, an algorithm, or computer operated, and it's clunky and hard to use. It takes a long time. Usually gets denied the first time they have to put in the initial information.

There are cost saving measures for insurers that are implemented at the expense of others.

INSURANCE COMMISSIONER VOSS: Okay.

MS. FREEMAN: And Commissioner, I might add to that. I'm Jeanine Freeman. I would like to build on what Dr. Reiter said on that issue. That is the No. 1 concern in terms of specific programming that insurers in Iowa right now, and it's a national move, the costs that that means for the health care provider and managing precertification for imaging, cardiology, oncology as well.

And I might note that we had discussions with Wellmark regarding their program. And when Wellmark talks about cost savings they do factor in the costs that they bear relative to having an

imaging program, working with their contractor to conduct the administrative processes associated with the program. And then they talk about the cost savings that they believe they realize with that program.

But the question we said to them in doing that, how have you factored in the providers costs. The providers cost has never been factored in to any of that kind of programming. We do have practices that because of the level of imaging that they do they have had to hire anywhere from one to three staff people just to manage these certification programs.

Dr. Reiter's absolutely right, the other very aggressive certification programer is UnitedHealthcare. That is, at least in terms of a specific program, very high on our list of our doctors in Iowa right now, and probably nationwide too.

INSURANCE COMMISSIONER VOSS: So, Jeanine, are you saying that in a clinic they're hiring one to three people? When you say a clinic, are we talking over five docs, over ten docs?

MS. FREEMAN: You know, one practice that called in that talked to me was a cardiology clinic.

When we went to the cardiology edit, or the system for certification, I think they probably have 12 cardiologists. But because of the nature of what they do as a specialty, they had to hire three staff people.

INSURANCE COMMISSIONER VOSS: Okay.

MS. FREEMAN: Now, how that would be for a small medical practice, I couldn't tell you for certain. Maybe they would assume that within the staffing that they already have. The time that it takes is very, very frustrating for them.

INSURANCE COMMISSIONER VOSS: Is it mostly for specialties?

MS. FREEMAN: Usually it's high-end radiology services that can effect any medical practice if they are referring for a PET scan, or CT, or MRI. And then there is a special program for cardiologists, and as I understand it, for oncologists as well.

INSURANCE COMMISSIONER VOSS: Okay.

MS. FREEMAN: So those two specialists.

MS. STROUSE: Marcie Strouse. Do you have to do the same precertification with a Medicaid patient or Medicare patient that you would with the private market?

MS. FREEMAN: It depends on if Medicare or Medicaid adopts a similar type of program. Now, my--I would need Dr. Reiter to verify for certain--I don't think Medicare has gone to a radiology precertification program.

Now, they also, doctors will experience, and maybe this is a way of just saying generally preauthorizations, prior authorizations, are very time consuming for a medical practice and for hospitals.

MS. STROUSE: And for patients waiting for care.

MS. FREEMAN: And patients waiting for care. The drug area is particularly. That's kind of what started the whole concept.

MS. STROUSE: Well, just in my defense I've got children that are--have special needs, and so I have dealt with a lot on the Medicaid and private market because I have both combined. I tended to find having a harder time getting preauthorized with the Medicaid than I did the private market. That's the only reason why I brought it up, to see if you're seeing those complications on both sides.

INSURANCE COMMISSIONER VOSS: Has the medical community done any studies on additional

costs because of all of this paperwork and preauthorization?

MS. FREEMAN: I cannot recall that the AMA has a specific study. They have run a survey. This summer they did run a survey, and they have not published the results of that survey yet on the specific preauthorization, prior authorization.

Now, the medical community does recognize that when--like Wellmark would say to you we saw just a balloon in utilization and that, like, high-end radiology. We needed to capture or hope that we could educate providers about how they better order or don't order in that area and maybe steps they take beforehand. Kind of like a three-step process to drugs, don't order this drug for this patient unless you use this course of drug therapy first.

The doctors recognize why Wellmark is concerned, or other insureds are concerned. Part of what they'll say is you just have to make it--if you're going to run programs like this, you have to staff them better. They can't take this much time. At some point when you see that, for instance, Dr. Reiter never has had a denial, take him off, don't keep him on.

There are practical suggestions that often

doctors will make that insurers are reluctant to necessarily comply with because of what they're finding in terms of the results of those studies.

What I'll do, Susan, is I'll look to see where the AMA is at with their survey on this issue.

INSURANCE COMMISSIONER VOSS: I would just be curious to know if there's anything out there that says, you know, based on our costs, the percentage of the underlying costs of running our system, whether it's a hospital or clinic, due to X is Y.

MS. FREEMAN: Exactly. Exactly.

INSURANCE COMMISSIONER VOSS: I'm assuming you have some kind of breakdown; here's personnel, here's bricks and mortar, here's this.

DR. GOERTZ: Christine Goertz. I'm just curious if you've looked at the gap. Because every CPT code has a practice expense component and it's supposed to consider these kinds of things.

I'm just wondering--I know the AMA went through a big reorg with practical expense over the last couple of years. I think one way to address this would be to identify the gap. Each CPT code has a list of services and the exact times those services or staff associate with each code. Identify the gap between what is in the code and what is actually

being spent, would be a good way to approach that.

MS. FREEMAN: I don't think the codes, and I may be wrong, and, Sandy, you can also correct me too, as I understood for the payment codes, at least under Medicare and the system that they use, it recognizes physician time and work effort, I don't know if it recognizes the time of your--

INSURANCE COMMISSIONER VOSS: Staff.

MS. FREEMAN: --office clerks.

DR. GOERTZ: It does. There are three components. One is the physician work time, the other is malpractice insurance, and then the third is something called practice expense, which that includes staff time and other things that are associated with putting that--with actually delivering the service that's described by that code.

MS. FREEMAN: Except it doesn't. That practice expense, we've talked about that a lot, talks a lot about maybe wages, but in terms of the actual, for your nonprofessional or your nonphysician staff, I don't know if--I mean, I'm not convinced that it would talk about individually factoring in a new insurance certification program.

DR. GOERTZ: Only if it became so general that that was the time it was taking. If it becomes

so widespread, or if you can build a case. It's just one way to think about it.

INSURANCE COMMISSIONER VOSS: Anne.

MS. KINZEL: Anne Kinzel. I think it would be pretty difficult from a research perspective to do that because a lot of time constraint and time spent is going to be on the relative sophistication of the practice. It would be very difficult to come up with a methodology that would give you a reasonable result.

MS. FREEMAN: I think what some states are doing, as another potential avenue, is looking at some uniform regulations for insureds that adopt programs like this. Of course, that's often where we're coming back to your division to say, and this is where the Federation and IMS, and others, will have debates about what's really appropriate in terms of regulation.

That is something that I could also work to provide some information on to the Division regarding what some of those regulations are.

INSURANCE COMMISSIONER VOSS: Okay. Do you know if any other state is--

MS. FREEMAN: I know--I think we probably have three states that have probably gone to

regulate. Very small.

MS. ROBINSON: Do you have copies of those regulations? I would suggest providing those also.

MS. FREEMAN: Okay. That sounds great.

INSURANCE COMMISSIONER VOSS: What are some other, kind of the list here?

MR. BOATTENHAMER: Greg Boattenhamer with the Iowa Hospital Association. Just picking sort of a random order, when we talk about cost drivers within the system, certainly on your bullet C, claim forms/payment systems/mechanisms, the variety of systems that hospitals and physicians have to manage and deal with is a huge cost driver for us.

One of the suggestions we've had, particularly with the changes that are coming with the federal health reform, is perhaps we ought to look at standardized systems of claims processing. Because right now when we deal with government payers, as the hospital community, for example, more than half of all claims revenue, however you want to measure it, is coming from government payers, i.e., Medicare and Medicaid.

Quite often insurers, particularly large insurers, or out-of-state insurers, have different ways of processing both claims and payments,

particularly the claims side. Those create a duplication of effort administratively within organizations that supply health care as they have to double up on their software.

Understand that the variations that are in place, we've had examples in the most recent past, for example, where, perhaps, Medicaid will move to one system at the same time Wellmark is moving to another claim system, and we deal with many out-of-state carriers as well, and perhaps more competition in the marketplace.

We believe that-- We're willing to look at that. That's--we'll talk about costs imbedded in the system, administrative costs to providers dealing with multiple variations in claims processing and other business practices that I think are primary cost drivers, in my opinion.

INSURANCE COMMISSIONER VOSS: But given that Medicaid and Medicare have a much larger percentage of the health care dollar payments than private insurance, are you suggesting that everybody should kind of go on the same system as Medicare and Medicaid? I don't know what their system is. I don't know.

MR. BOATTENHAMER: At one point I had all of

the acronyms written down. The bottom line is, particularly when it comes to 2014, we're going to have an even more significant number of patients that are on the Medicaid program in Iowa, and across the nation. It seems counterproductive for us, as we try to both statewide and federal level, try to get a handle on health care costs and still allow these multiple claims processing and multiple administrative processes to be in place.

We're not suggesting a single payer health care system. Certainly the methodologies are sophisticated enough to be on the same side. I don't believe that's true. I don't think we're talking about a single payer system. We're talking about a single process.

MR. TEELING: Joe Teeling.

Do all of the hospitals have their own similar systems how they pay, how they count the money? We have 119 hospitals.

MR. BOATTENHAMER: We don't operate the same way insurance companies do.

MR. TEELING: Insurance companies don't operate the same way Medicaid and Medicare does. It's just a simple question. If I'm dealing with Mercy or Methodist and I'm billing them for a service

or reimbursing them, do they have the same systems?

MR. BOATTENHAMER: It doesn't translate to that. So what? You're submitting a payment to the system. It doesn't add costs on because their collection system is different, because of their internal cost accounting system.

MR. TEELING: Your payment system--

MR. BOATTENHAMER: You're paying who? Who does the hospital pay?

MS. STROUSE: You're paying out claims different than the next hospital.

MR. BOATTENHAMER: Hospitals don't pay claims.

MR. TEELING: I'm sorry. So you--

MR. BOATTENHAMER: Hospitals pay employees, that's all they pay.

MR. TEELING: You have a patient that comes through, they want to get--they want to get paid by somebody, patient, Medicare or Medicaid, or insurer; right? So your hospitals have to bill the insurers.

MR. BOATTENHAMER: But at the request of the payers. If we want to get paid by Wellmark, we have to file one kind of claims processing. If we want to get paid by Medicare, we have to file another claims process. If we want to get paid by United, we file

yet another system.

Those are not systems inherent to the health care provider, those are the demands placed on the health care provider. I don't know if they are exactly the same, but, for example, the APG payment system is utilized on the outpatient provided by Medicare and Medicaid.

MR. TEELING: It's only going to get worse because you're going to have more and more individuals that are going to have bigger and bigger responsibilities, so you're going to have to get money from them to help individually. That may have already been talked about.

MR. BOATTENHAMER: Well, sure. That's also a vagary of the payer. I mean, in the health care environment the hospital and the physician is not a business per se in that it doesn't have that direct payment relationship with the individual who receives the services.

MR. TEELING: They're going to get one, though. It's on its way.

MR. BOATTENHAMER: Well, you're going to suggest that every individual is going to have their own relationship with their hospital, and then we're going to go back to a noninsured system.

INSURANCE COMMISSIONER VOSS: And will there be a difference between those companies in the exchange and outside the exchange? Will the exchange all have the same--

MR. BOATTENHAMER: Who knows? Who knows? All I'm sharing with you today is we deal with multiple claims systems within health care.

INSURANCE COMMISSIONER VOSS: Are they that varied that it's--

MR. BOATTENHAMER: They're separate and distinct programs.

INSURANCE COMMISSIONER VOSS: Right. But how much different are they that if you sat down and wrote all payment systems have to be similar, how big a change is that, the claims system?

MR. BOATTENHAMER: I don't know. I know that, and maybe you can help me with some of the acronyms, Wellmark has just moved to an advanced ambulatory patient group versus Medicaid's ambulatory patient classification, APC. It's another generation ahead of, more sophisticated, from the insurers perspective, more sophisticated. But it puts-- I know it's a separate group. It's a separate claims experience from the computer system inside the facility.

Those are added costs to the system. I don't know how anybody can deny if you have to have multiple ways of doing something that's going to add additional staff and multiple administrative costs within the facility.

INSURANCE COMMISSIONER VOSS: John, you had--

MR. GILLILAND: This was more interesting, but...

INSURANCE COMMISSIONER VOSS: Let us be the judge of that.

MR. GILLILAND: John Gilliland. Greg was one letter ahead of me. I was wanting to ask about B.

INSURANCE COMMISSIONER VOSS: Sure.

MR. GILLILAND: It's about the uniformity of applications, and things. I know we had worked on that a while ago. I wanted to inquire on the status of that.

INSURANCE COMMISSIONER VOSS: Right. I think it's done.

MR. GILLILAND: I thought so.

INSURANCE COMMISSIONER VOSS: Right.

MR. GILLILAND: Why was it on the list?

INSURANCE COMMISSIONER VOSS: It was part of

the discussion. We just want to see if anything had changed. I know in the past that, you know, I continue to say how come you ask these different sets of questions and can't it be sort of a one thing fits all in all applications. It came to the point can I have an app, whether it's individual, a small employer, just involves all one, and you just check the box. We brought it to see if anybody had had any thoughts or concerns.

MR. GILLILAND: All right.

MR. TEELING: You can tell them that this group accomplished something. Put it down on the list and get it sent in.

Can we go back just briefly to Greg's point?

INSURANCE COMMISSIONER VOSS: Sure.

MR. TEELING: I know we only have 54 more minutes.

To me I think it's impractical. I mean, Anne earlier talked about the practicality of figuring out some of these extra costs that the providers are having to go through because all of the practices are not uniform. Some of the small ones would be very hard to figure out.

I don't know about hospitals. Why couldn't the hospitals demand that any system out there

interface in some way with your reporting? I mean, are you at--wouldn't that be easier than having all of these systems change?

Wellmark's new system is probably costing them $50 million. Are they going to just go switch it again? Medicaid is going to switch it when they have one system. Once it becomes antiquated how are you going to get everybody to move to the new one? How are you going to have competition of systems? Isn't there a way that hospitals can dictate that?

DR. REITER: The guy with the money makes the rules.

MR. TEELING: Just asking.

MS. FREEMAN: In Iowa a physician practice, and Dr. Reiter can correct me, we will be dealing with as many as 200 different health plans or programs of health plans. The more it can be uniform without the--

DR. REITER: Is anybody a technical person here? We're really talking about a digital computer output that talks to another computer. It receives digital input. The problems are the data outputs and data inputs have to be a certain format. It's not like we have a check box on the paper to say. I don't understand the system requirements, and I don't

understand the input and output requirements, but technically right now it's not possible to have common output that feeds into all of the insurance companies so they receive it in a format that they can read it. It has to be done different for most every carrier.

It would be nice if it would be more electronically uniform. It should make it easier for everybody, and it should reduce the overhead costs of both insurance carriers, as well as--for payers, as well as hospitals.

MR. TEELING: It sounds like a business opportunity for some technical firm that can come in and fix the interfaces between all the different clinics, providers and hospitals in all the different things.

INSURANCE COMMISSIONER VOSS: What do you do with large self-funding?

MS. FREEMAN: They are very difficult. You work--

INSURANCE COMMISSIONER VOSS: We have no--

MS. FREEMAN: --through your third-party administrator.

MR. BOATTENHAMER: Quite often, it could be Wellmark, for example.

INSURANCE COMMISSIONER VOSS: But I'm assuming you might have some large ones that do their own thing, or not many?

DR. REITER: Principal, for example, is self-funded.

INSURANCE COMMISSIONER VOSS: But is the self-funded on the same platform as their insured business?

UNIDENTIFIED SPEAKER: Mostly.

INSURANCE COMMISSIONER VOSS: Okay.

MR. SKOW: Bob Skow. The only thing I would caution, though, I think Joe is on to something here for a moment. Don't lose the fact that workmans' compensation, auto insurance, they have a real hard time deciphering what all of the doctors in the hospitals are sending them for the same kinds of treatments for claims.

Joe has kind of an approach, I don't want to steal Joe's words, a two-way street here. It is impacting other lines of health care reimbursement. You know, all these people, if you're going to bring them to the table, then you need some folks that are not in this room today.

INSURANCE COMMISSIONER VOSS: Can you explain that to me, Bob?

MR. SKOW: Workers' compensation, clearly once it gets assigned, and they pay usual and customary under Iowa law, it's been a running gun battle for years deciphering what the different payments of reasonable and customary are out there.

There have been carriers, especially out-of-state carriers, who refuse to pay some bills, and then the employee gets in the middle of it. Of course, we don't allow balanced billing to the employee by law either.

I only bring it up for the fact that there are other players here that reimburse for health care services besides health insurance. At least they ought to be part of this debate if there is a discussion.

INSURANCE COMMISSIONER VOSS: That's a good point.

MR. TEELING: It would be very helpful to quantify the numbers. We know we spent $22 billion on health care last year in the State of Iowa on all different sources. Of the $22 billion, are we talking about $5 billion of it being this extra burden? Is it a billion?

It would be nice. I don't know how you get around to that. It's very difficult, I would

suspect. Because if it's a billion dollars it might not be worth the $4 billion it takes to fix it. You follow what I'm saying? It's a complicated issue, extremely complicated.

I know it's very expensive and it's a burden, but how much of a burden and how much is it going to cost to fix it? Maybe we would be better off spending that $4 billion somewhere else. I don't know. I'm just pointing it out.

INSURANCE COMMISSIONER VOSS: I think another thing that's raised through all of this now with the federal government telling us what percentage of cost can be administrative and what percentage must be for health care, I think people are watching. You know, as Senator Dirksen said, a million here, a million there, now you're talking more money.

As we try to slice that 15 percent down every dollar saved helps. I think there is at least for now a study to see what the costs are. I know they just came out with a study on med,mal costs too, which I don't think was as large as people thought it was going to be. I have a mandate here.

MS. FREEMAN: Commissioner, another thing I might offer, just in the lines of this study, and

when you made your opening remarks it seemed that you were looking at more kind of the technical administrative side, claims and claims payments as opposed to coding and other things like that.

The federal health reform law talks a lot about administrative simplification. I think that's where you were going, Greg. Some of the things that we think, No. 1, we were really pleased to see that language in the national health reform law.

One of the long arms of administrative simplification usually has been the HIPAA electronic transaction standards. I know at least--in the long run kind of what I was saying is that to achieve true administrative simplification at some levels it's going to be nationally driven and then supported in your states for purposes of accomplishing the goal.

We still do not have good implementation on many of the HIPAA transaction standards that were designed to save tons and tons and tons of dollars, and I would say most doctors and hospitals will say we haven't seen a savings yet. Maybe the health plans would say the same thing.

Along those lines too, I would say one of the key features that some of our doctors, and I think nationally through the national Medical Group

Management Association, is the whole issue of eligibility. Eligibility determinations at the time of service, having eligibility clear.

Our practices sometimes will spend an inordinate amount of time, when you're dealing with something like a $98 claim, and you spend, over the course of three-and-a-half years, debates about who really should be paying that claim. What our practices sometimes will find is that they had good information from the patient about eligibility, but another health plan would say actually on that day we weren't responsible, somebody else was.

You might have two years later one health plan saying pay us back and the other health plan saying too late. Some of the costs-- For us that manage the claim, there's the cost of all that administration associated with eligibility, as well as the cost of going back and forth. And then the costs potentially of never being paid despite the fact that your covered life had two insurances that should have been responsible.

I think another big issue to me, this group is kind of an administrative simplification group, and that would be a tremendous assistance in terms of the whole eligibility process. That was just another

thing that I would throw on the table.

I know, Dr. Reiter, you also have--I saw your hand up earlier.

DR. REITER: Credentialing was the first thing, so I wanted to ask a question and comment on that.

Maybe I'll start with the comment. Credentialing is complicated and it's kind of a nightmare. It would be valuable, I think, if there were credible and certifiable ways to centralize credentialing from all of the providers in the state that would satisfy institution requirements. Right now independent record searches for everybody that has to do it is very costly and wasteful. Every hospital, every health plan, every medical group, plus the state, all have to do the same process.

The result of that is that it makes the insurers very, very conservative. And, as you know, there was an effort in the Legislature to reduce the delays in credentialing that create access issues with providers. Right now it's 60 to 90 days for major payers to finish their credentialing process after a physician, say a physician finishes residency, and they don't start until they receive the residency certificate. The certificate of

completion was issued, like, on June 30th. Most people are starting work in September to November depending on when the credentialing is begun because you can't let people work if they're not going to be paid for any of their work. Medicare used to pay retroactively, but now they'll only go back 30 days.

There was maybe, I believe, legislation two years ago looking at asking for regulation to be written that would mitigate this for Iowa in some degree that would force insurance companies to pay retroactively, pay claims retroactively, at least for a period of time. I'm not sure that that's occurred.

Something to try to, No. 1, simplify credentialing. Centralize credentialing would reduce overhead costs for everybody, if it could be made compliant.

INSURANCE COMMISSIONER VOSS: Who is credentialing at the state level?

DR. REITER: Board of Medicine.

INSURANCE COMMISSIONER VOSS: They're doing it initially?

MS. FREEMAN: Uh-huh. It's really the licensure application.

INSURANCE COMMISSIONER VOSS: Okay. But then does anybody just say if you've been licensed by

the Board of Medical Examiners you're in like Flynn?

MS. FREEMAN: That was the old way.

INSURANCE COMMISSIONER VOSS: When did that change?

MS. FREEMAN: I don't know when it started, but credentialing kind of drives a little bit from a privileging process in hospitals, but I think insurers also said licensure is not enough, we want to be able to verify.

What I might mention, Commissioner, is that we do have the Iowa Credentialing Coalition, which is just a voluntary organization, which I know you are familiar with, and Paula is too. We, as a coalition, were working with the Board of Medicine.

This might be something to follow up on with the Board of Medicine. Could we get a system in place in our state where the board itself does a lot of primary source verification in the licensure application process, and is there a way through the computer system in the data base of the Iowa Board of Medicine to simply say once we have verified the doctor's graduation from an accredited school, and all of the things associated with the licensure process, that no insurer, nor any hospital in this state, would have to go through primary source

verification on the same thing. They could rely upon what the Board of Medicine did. We just--we were not able to accomplish that goal, and that's something--

INSURANCE COMMISSIONER VOSS: Greg, when you wanted--when a doctor wants to have privileges at a hospital, do they have to go through another separate--

MR. BOATTENHAMER: Yes. Hospitals have their own credentialing processes as well.

INSURANCE COMMISSIONER VOSS: Why is that?

MR. BOATTENHAMER: I think there's a couple different reasons. Probably talking, when you're talking about employee physicians, for example, you're taking on medical malpractice--

INSURANCE COMMISSIONER VOSS: Okay. I can see that as being a little different.

MR. BOATTENHAMER: --risk, and some other things like that.

There is a credentialing process in every hospital. It's largely driven by the medical staff. It's separate from the credentialing process from the insurers. We believe we have addressed that within the last two years. We do have language to require insurers to pay clean claims in between the providers credentialing processing and the insurers

credentialing process being completed.

In other words, there is this retroactive period. In fact, this last year we were able to extend that through PA's and advanced nurse practitioners.

I don't know if you are familiar with this, we have sent some people your direction because we know some of the Iowa State carriers are not complying with that state law. But it is, in fact, state law that insures a business in the State of Iowa has to at least recognize that today.

INSURANCE COMMISSIONER VOSS: But if I'm not an employee of your hospital, but I want to have privileges, is it enough that the Board of Medical Examiners has--

MR. BOATTENHAMER: No. No. Hospitals have credentialing practices that go across the board, and hospitals also have different procedures. It is not enough in the State of Iowa, I don't know anywhere in the country, where you can just say, "I'm a licensed physician so I have a right to practice in your facility."

INSURANCE COMMISSIONER VOSS: I'm not saying you have a right, but you can just review what the Board of Medical Examiners has done and that would be

your application.

DR. REITER: I don't believe that's been institution compliant. It's required. The hospitals also do independent primary source verification of medical school, residency completion, to get those certificates independent of wherever else people may have applied.

If someone graduated from medical school in Spain or Iraq, they have to contact that medical school, just like everybody else is doing, and get a certificate from the medical school out of the country. We have what, how many--what percent? It's a big deal. That part of it, that part of it is what I think is redundant and unnecessary.

Credentialing has to do with competence. That's a different adjudication. But to be able to say people graduated from--

MR. BOATTENHAMER: Share the same documentation.

INSURANCE COMMISSIONER VOSS: So you can have somebody, I'm going to play devil's advocate, you can have somebody who graduated from medical school and is licensed by the Iowa Board of Medical Examiners, and you would consider them not competent to practice medicine?

MS. FREEMAN: It's privileging, Susan. I think that's the difference.

INSURANCE COMMISSIONER VOSS: So why aren't you just yanking their license?

MS. FREEMAN: What I will share with you is you're privileged to do neurosurgery, but you're not privileged to do--

INSURANCE COMMISSIONER VOSS: I got you on that one.

MS. FREEMAN: That's where the distinction comes in for hospitals.

INSURANCE COMMISSIONER VOSS: How is your process? If a hospital needs a pediatric oncologist to show up at your door--

MR. BOATTENHAMER: I can't tell you. I don't know. It's vastly different if you're credentialing primary care physicians in rural Iowa versus pediatric oncologists. There might be what, a dozen of them in the state.

INSURANCE COMMISSIONER VOSS: I guess I'm trying to figure out where the Board of Medical Examiners fits into all of this, if they have some role that they play to make the process smoother and perhaps less costly.

MS. KINZEL: The difficulty comes from the

history of hospitals as self-governing institutions, and so they want to get their two cents in on the credentialing--

INSURANCE COMMISSIONER VOSS: Yeah, Greg.

MS. KINZEL: --the credentialing side. Not even hospitals, any medical practice does the same. The problem is how do you divorce the licensure, which says a person is competent to practice in the state, and the credentialing, which says the person is competent to bill from that source.

I think that seems to be where the rub comes in terms of speeding it up.

MS. FREEMAN: I think terms are important too, Anne. There's licensure, there's credentialing, and there's privileging.

MS. KINZEL: Yes.

MS. FREEMAN: A hospital does two things; one is through the medical staff, basically assuring that licensure is in place. Then, secondly, privileging for what that doctor can do in that situation.

The insurer's credentialing process is much more akin to the licensure process, but they also are asking things about do you have medical malpractice insurance, and things that relate to is this

physician prepared to do what the physician claims he or she can do and be reimbursed by that insurer.

INSURANCE COMMISSIONER VOSS: So is there any process where you can foresee that the Board of Medical Examiners could help in the process and cut down on the time understanding that there are other circumstances that hospitals would need to look at?

MS. FREEMAN: Definitely on the primary source verification of many of the things.

Commissioner, I would absolutely be remiss on behalf of our medical practices if I also didn't just restate that's why we thought a uniform form was very important.

MR. TEELING: Uniform what?

MS. FREEMAN: A uniform credentialing form.

MS. STROUSE: I thought there was a common form.

MS. FREEMAN: There is, but not all of the insureds use it. That means doctors have to fill out new forms, depending on the insurance company.

MS. STROUSE: Do you see more problems with the out of state not using the common form versus the insurers in-state?

MS. FREEMAN: It is. The national insurers use their own forms. Now, by way of contrast,

UnitedHealthcare is an insurer that says you must fill out our form. Coventry, a national insurer, says you can fill out your own form, you can fill out the Iowa credentialing application form, or you can fill out our form. We can be adaptable and manage all that. The national, like UnitedHealthcare, wants everything coming in on their form.

There's also this other process, insurers supported.

MS. DIERENFELD: CAQH, there's a multistate form that all of our insurance companies use.

MS. FREEMAN: Wellmark does not. UnitedHealthcare does, but Wellmark does not. That's where they-- We also study should we try to adapt in Iowa to--

MS. DIERENFELD: The reason--you're refreshing my memory, Jeanine. We had this conversation ad nauseam during the legislative session, and I've forgotten some of the details, but I'm starting to remember it now.

The reason why Wellmark does not use that multistate form is because they only provide services or pay for services here in Iowa. They are a one-state company. Whereas the other companies, they use the multistate form. They operate in multiple

states, and so they use that form that other insurance companies that do operate in multiple states also use. It's a national form.

MS. FREEMAN: It is.

MS. DIERENFELD: That's where most states are moving. Some states that used to use and authorize the single state form are actually moving to a multistate form that is dealt with by the CAQH. That's a trend.

INSURANCE COMMISSIONER VOSS: Everybody, even UnitedHealthcare, is moving to CAQH?

MS. FREEMAN: They have moved to CAQH because they contract with CAQH.

Essentially what that means is the cost has shifted back to the doctor if they have to fill out multiple forms. UnitedHealthcare says it's too costly for us to manage more than one form, so it goes back to the doctor. And then Iowa is probably the only state in the nation that worked to develop a uniform form for using this. It's done on a voluntary basis, and it's been recognized by JCHO and NCQA as really a very good form.

Of course, we were hoping that everyone would use it, but not everyone does. That's just an expense that kind of highlights why administrative

costs are there.

INSURANCE COMMISSIONER VOSS: You know, I'm not sure there's much we can do about out-of-state care expenses. That's not really in our bailiwick.

DR. BURNHAM: I have a question on that. Is out-of-state care expenses, and I'm a dentist so it doesn't effect me anyway, a major issue for insurance carriers in the state? When you look at Iowa, what their fee schedules may be and what may be reimbursed versus, let's say, somebody in New York, somebody visiting New York and has an injury, it's billed back to the insurance carrier here, you can probably count on multiples in terms of fee expenses. Is it an issue costwise in the State of Iowa? This is more curiosity.

INSURANCE COMMISSIONER VOSS: Yeah. I don't know. That's one of the issues that came up in our discussion.

MS. FREEMAN: Commissioner, one thing that I would say in response to your question, I read that as, for instance, Wellmark Blue Card program. Our practices will be concerned about that when they have a contract with Wellmark in Iowa--we've had these discussions with Wellmark, I don't feel we're speaking out of school relative to Wellmark not being

here--if the patient is a patient in Iowa, but covered by a Blue Cross plan somewhere else not in Iowa, then the doctor who has the contract to provide services to a Blue Cross patient in the state, however, will be paid by the out-of-state plan's rates. I believe Wellmark makes the payment under the Blue Card program. We're saying--

INSURANCE COMMISSIONER VOSS: It seems like it's very complicated to me.

MR. SUNDSTROM: I don't know the details about it. I know that Blue Cross and Blue Shield Association generally across all the different entities that are licensees in that do have a mechanism for allocating costs.

If an Iowa person covered by Wellmark is injured in Massachusetts, and whoever it is out there on the east coast is the Blue Cross/Blue Shield, then there's a way that payments are allocated through the system, which presumably is seamless for the patient. The patient has coverage, they get paid, and the payments happen among the various carriers involved and the providers. And that's, obviously, a very complex practical issue both intrainsurance industry and then between the carriers and providers.

INSURANCE COMMISSIONER VOSS: Okay.

MR. SUNDSTROM: I would assume multistate companies like UnitedHealthcare, they don't have to deal with that. But Blue Cross and Blue Shield have territories.

INSURANCE COMMISSIONER VOSS: I'm going to bring up, these are two things that hit me personally, and tell me how we can do these better.

No. 1, every time my husband goes to the doctor, and he goes to a chiropractor like twice a month, I get a paper EOB. Can I just get an electronic EOB?

MS. STROUSE: You can with Wellmark, but I'm not sure... You can pick and choose with Wellmark.

INSURANCE COMMISSIONER VOSS: No. 2, I just got billed by a provider here in Des Moines and when I got the bill I thought, well, I haven't been to this provider for three months so why am I getting a bill all of a sudden. I'm assuming it took three months to figure out what my share was.

Can I ask from now on that my bills be done electronically just like I do with Qwest, Target, everybody? Do I have to-- Am I required to get a paper bill from a provider? I'm assuming no. Couldn't I just go, when I go to the doctor's office, check a little box that says from now on you can send

me all my bills electronically just like you do when you get your Qwest, set up your Qwest account? Is there anything in HIPAA that would--

DR. REITER: There might be. Because electronic transactions have to be on a secure link and HIPAA compliant. It might not be allowed.

INSURANCE COMMISSIONER VOSS: Well, it's not my Facebook account.

DR. REITER: No. I'm serious. For example, I'm not allowed to communicate with patients by e-mail, and the reason is it's not--even though it's encrypted, it's not a secure link, and, therefore, it's subject to hacking, and so...

MR. SUNDSTROM: If you had an affirmative option consent.

MS. STROUSE: Or if you had like a password protected place where you could go and pull that stuff down.

MR. BOATTENHAMER: Let me give you an example. This past year we passed legislation, it has to do with hospital notification, law enforcement, once someone voluntarily, a patient is going to be released, that communication between the hospital and law enforcement has to be encrypted, even to say Joe is ready to go. That's all it's

saying. It's interrelated. It all has to be encrypted.

I think the other piece of that that's going to be a little bit more difficult is when you compare your health bills to Qwest, just sort of an ongoing monthly expense. Many people don't see health care providers for a couple years in between, or something like that. It's not as routine of a transaction.

INSURANCE COMMISSIONER VOSS: Yeah. Okay.

MR. BOATTENHAMER: You get that. I mean, I don't know if that is a factor in just the reality of it. I do know on the first point that HIPAA and the encryption, and all of that stuff, is a huge problem if you are dealing with administrative notification, much less a bill or something that would have a CPT code on it.

INSURANCE COMMISSIONER VOSS: Certainly I know there's a difference between paying a Qwest bill and health care bill. Even for people younger than myself they do everything, they pay every other bill, it just seems like a lot of paper. Especially, and I'm just saying, as an example, my husband, or somebody who maybe goes regularly. That's a lot of paper.

Is there anything preventing, even if it was

like, I only want to see my EOB every four months?

MR. BOATTENHAMER: Your EOB is different from your bill.

INSURANCE COMMISSIONER VOSS: I know. I get both of those separate. Is there anything preventing me from that, or just making it...

MS. FREEMAN: That's only the insured, the EOB.

INSURANCE COMMISSIONER VOSS: Bob, can we get our bills from our insurance--

MR. SKOW: They have to be encrypted, and people will ask for them.

INSURANCE COMMISSIONER VOSS: But you have some of your customers or clients, they don't get a paper bill?

MR. SKOW: Policies are done that way.

INSURANCE COMMISSIONER VOSS: Everything?

MR. SKOW: Yep.

INSURANCE COMMISSIONER VOSS: Really? You can get all that done electronically?

MR. SKOW: It's the same information, and so on.

MS. STROUSE: Summary plan descriptions.

INSURANCE COMMISSIONER VOSS: But that is--

MR. SKOW: Everything's gone that way.

MR. TEELING: What do you think about that? I don't know the answer to that.

MS. DIERENFELD: I don't know the answer to it either.

MR. TEELING: I think you're probably right, it would be difficult. The EOB you ought to be able to send electronically.

MS. STROUSE: Wellmark does give you the choice of one or the other. You can't look online for your EOB if you want it paper. You can go in and change it. I mean, you can just make that effort to do it. But honestly a lot of people don't even look at their EOBs, so if it went to electronic--

INSURANCE COMMISSIONER VOSS: The problem anymore is I'm so used to getting it most of the time I throw it away. God forbid they would send me something important like--

MR. TEELING: A check to go along with it.

MS. STROUSE: You can get online and access your EOB. Every carrier does that. I just don't know if they allow you to pick. I know Wellmark does, but I don't know if you're allowed to pick one or the other.

MR. TEELING: It's a brilliant idea.

DR. REITER: From a HIPAA standpoint I think

you can argue that they're incomprehensible to anyone, even the person who is seeking it, and, therefore--

MS. STROUSE: I understand them.

MS. KINZEL: One thing I don't understand is that in a zero co-pay why do they send an EOB?

INSURANCE COMMISSIONER VOSS: I have no idea.

MS. KINZEL: I mean, it's not all EOBs are the same in terms of practical value. It seems to me if you belong to a plan where a whole class of services has a zero co-pay, it's insane to send an EOB.

MS. STROUSE: They want you to know what your benefit is. They want you to know that your provider charged $89 for your services, but it's free to you, your insurance is paying for that. It's just that--

MS. KINZEL: That's not free, I'm paying for my insurance.

MS. STROUSE: No, I mean, your co-pay. You have a zero co-pay.

MS. KINZEL: At the end of the day if we're talking about administrative simplification there has to be a notion that information received has some

sort of action benefit to the person receiving it.

INSURANCE COMMISSIONER VOSS: How is that going to effect exchange in 2014 when they want us to do it all online? Most people don't have a secure line on their computer. How do they expect us to do all of this?

MS. STROUSE: And I have clients that don't own computers. Honestly, if you go to the public library will they feel comfortable pulling up all their health information at the public library.

DR. REITER: EOB is different than the bill. Particularly the EOB, I think you're exactly right. It seems to me personally, this is my personal opinion, has no impact on anybody else, receiving an e-mail or a communication, your EOB is accessible to you at this website, please access if you're interested, would be sufficient.

INSURANCE COMMISSIONER VOSS: Right.

DR. REITER: They really do have very limited utility. I assume they are sent out both as a marketing tool and probably as a requirement.

INSURANCE COMMISSIONER VOSS: Do we have that requirement?

MS. STROUSE: I don't think there is a requirement. Wellmark you can choose and they don't

notify you.

MR. TEELING: Are you asking is there a requirement if you have to send an EOB out, if that's your claim? Is that the question?

INSURANCE COMMISSIONER VOSS: Yeah.

MS. STROUSE: I would think there would have to be some kind of a notification.

MR. GARRETT: One issue that's particularly an issue for us, if you go to look to drill down further on some of these costs, specifically for chiropractic, when I go to look at an EOB, when they go to populate an EOB, when Wellmark populates an EOB and it goes to the provider, we don't--I represent an IPA of about 400 chiropractors, the EOB does not put the billable and allowed on there, it's only the billable.

When we're going to look at costs savings and look at some of these issues, and I've talked to other states, our Wellmark is kind of an enigma that they don't have both of those on there. And for the life of me I can't figure out why they wouldn't put both of those on there.

INSURANCE COMMISSIONER VOSS: Just for chiropractors?

MR. GARRETT: I think it's for other areas

too.

MS. STROUSE: On an EOB that the patient receives it has all of that information on there. It clearly outlines what the doctor charged, what the discounted rate was, and what you owe.

MR. GARRETT: We don't get that. Because when they're submitting the EOBs, when the provider is submitting the EOBs, that is not on there. When they're-- Because we're trying to get all--

INSURANCE COMMISSIONER VOSS: I better look at Carl's EOB.

MR. GARRETT: Yeah. We're trying to get all of our providers to do electronic EOB submissions on everything, but there's no--there's nothing on that end that has the billable and the allowable on the provider side.

MS. STROUSE: What does it show you, only the--

MR. GARRETT: Only the billable, right, not the allowable.

MR. TEELING: They must--

MR. GARRETT: And I need to know that because that's great utilization management data that we're lacking at this point.

MS. STROUSE: It's probably literally

something in their system that just doesn't populate on your end.

MR. GARRETT: Right.

MS. STROUSE: That's weird.

MR. TEELING: I'd have to go look and see what her EOB says because she goes to the chiropractor every month. I'm almost positive she gets that information even with chiropractor services.

MS. STROUSE: I'm confident, too. And I do work with some self-funding groups and I can see the electronic EOBs that go out to them.

MR. GARRETT: Well, the electronic billing--all 400 chiropractors are on a standardized EDI platform in our IPA. The EDI company with whom we work also has indicated that Wellmark does not put that in. And they represent DCs, MDs, DOs, the whole gamut of providers. It's our Wellmark that's doing this and it's not just to chiropractors.

MR. TEELING: Are they not doing it on the other end, though?

MR. GARRETT: Right.

MS. STROUSE: Just the provider choosing it.

INSURANCE COMMISSIONER VOSS: The provider. You don't really know.

MR. GARRETT: We don't know.

MS. STROUSE: They think you know because you know what you billed, instead of what you're paying out.

MR. GARRETT: Exactly. We need to know the allowable. I need that information from a utilization management standpoint. I want to come back and say we want to make this a cost effective approach to health care, I need to know the billable and the allowable so I can be pulling my docs back into where they need to be as it relates to utilization management. They need to be meeting these certain criterions within our utilization management.

MR. TEELING: But the other companies don't have that problem.

MR. GARRETT: Right.

MR. TEELING: United--

MR. GARRETT: The other companies do it. It's Wellmark that's not doing it.

MS. DIERENFELD: Have you talked to Wellmark about that?

MR. GARRETT: They said it's a system problem, not you guys. I said I know that. I know that. But I can't imagine that they can't fix that.

That's--it seems really simple to me. I don't know. Maybe I'm oversimplifying it.

MR. TEELING: Sounds like you just need to go talk to them.

MR. GARRETT: Yeah. We have. We have.

INSURANCE COMMISSIONER VOSS: What other issues?

MR. BOATTENHAMER: One of the things that you might want to consider, and I don't know if it's legislatively, but certainly something that we would like to challenge the insurance industry to help as we begin to look more at, we talked earlier this afternoon about preventative services, chronic abuse management, of course, is a big area of concern.

All of that was tied up, along with utilization, with the premium increases from last spring. The federal health reform is sort of silent on how we are going to do some of this stuff.

From our perspective, the organizations that have large payers are the organizations that have fairly robust claims data. Perhaps there is a way that they can extrapolate, in aggregate, some of that claims data to help identify, either for public health or for the providers, different experiences that we believe the provider community is best able

to respond to.

That's a long way of saying, for example, if Wellmark knows that there is a higher incidence of diabetes in Des Moines than other places in the State of Iowa, if the provider community knew that, I think that they could respond in a more proactive manner and with preventative measures to try to interact more preventative and chronic care management strategies in communities where they know what the problem is.

Whereas, independent individual practitioners aren't going to know that because you don't know what the entire environment looks like. You can know your hospital, for example, that you see a higher incidence of diabetes than statewide or national averages, but is that actually representative in the community at large.

MR. TEELING: Wouldn't you know where they were from in your hospital? Basically you know where they're from. Like if I go into Mercy they ask me my address. I have to fill out this whole form that tells them everything about yourself.

MR. BOATTENHAMER: Sure, within your facility I think you can identify those--some of those things. But we think from an aggregate basis,

statewide basis, can't we see some patterns that might be helpful.

INSURANCE COMMISSIONER VOSS: I think that's something that you would have to bring with Medicaid and Medicare.

MR. BOATTENHAMER: I didn't say Wellmark, I said large payers. I think you have to look at all of the large payers.

INSURANCE COMMISSIONER VOSS: Didn't we do that a few years ago on C-sections? How many years ago was that?

MR. BOATTENHAMER: Yeah, I think in my career I think we've done that.

INSURANCE COMMISSIONER VOSS: Where are the places around the state.

MR. BOATTENHAMER: Again, it's not looking at any data mandate, but it's trying to say are there patterns that somehow in the State of Iowa that we can identify, do we have the resources through the payer community to identify some targeted areas that we all recognize are health issues in Iowa, whether it's diabetes, or obesity, pick whatever you want. Are there patterns in different places in the state.

INSURANCE COMMISSIONER VOSS: That sounds like a good project for public health.

MR. BOATTENHAMER: I don't think I said the Insurance Commission.

MS. DIERENFELD: And that kind of segues into some comments I want to make. And I don't mean to overwhelm you with a lot of stuff here. We weren't exactly sure where this conversation was going to take us today so we came with a lot of stuff.

MR. GILLILAND: Are you going to read that into the record, Paula?

MS. DIERENFELD: When we looked at the purpose of this meeting today we kind of looked at the bigger picture than some of the smaller computer administrative-type things.

When we were thinking about what can we do to deal with the rising costs of health care and the rising costs of health insurance, we really looked at more of the--we talked more about the preventative type of things that we can do, the lifestyle change type of things we can do.

What I have for you in this packet of material, I found these articles very interesting, Commissioner. There are three or four articles in there that talk about obesity and the recent CDC study that talks about the increasing prevalence of

obesity.

You will see in there that in this recent study what they've found is that nine states now have obesity prevalence above 30 percent compared to three states just two years ago, in 2007, and no states a decade ago.

I mean, if we want to reduce the cost of health care in this state, I mean, what we need to do is we need to address some of these health choice decisions that people make, lifestyle decisions that they make. As we all know, if someone is obese they have potentially many chronic issues, whether it's diabetes, or heart disease, or whatever. That's what's really driving up, to a large extent, driving up our health care costs.

INSURANCE COMMISSIONER VOSS: This is an issue that's near and dear--

MR. TEELING: That's what we're starting in two weeks.

INSURANCE COMMISSIONER VOSS: We'll e-mail these out to everybody.

MS. DIERENFELD: And there's also some good testimony in there from Karen Ignagni from AHIP where she talks about all of the cost drivers that are pushing up health care policy and health insurance

premiums. Of course, as we know, health insurance premiums increase in tandem with health care costs, 7 percent annual per year for the last decade. I mean, when health care costs go up our health care premiums go up because they pay for those costs.

There's also, related to another item that you had on the agenda that we haven't talked at all about, impact of the federal health care reform legislation. There's also a couple of studies in there that were just recently released, one by CMS and one by Mercer, that talk about how federal health care reform is going to impact health care costs and health insurance costs.

Contrary to what CMS earlier found, they are now saying that health care reform is going to increase those costs even higher than what they previously said. The Mercer study talks about health--how those increased costs, because of that, are going to change the way employers approach some of their decision-making in terms of coverage, and things. Both very recent studies and lots of really good information in both of those studies related to that issue.

The other thing that I would just mention in the Karen Ignagni testimony, she does talk about what

is happening across the country in terms of what health plans are going to deal with, some administrative simplification or payment reforms. We can have some conversation with our companies in terms of to what extent are they looking at doing similar things here in Iowa, but certainly it's something that's being looked at on a national level and being discussed, and I'm sure other companies are looking at doing some similar things.

INSURANCE COMMISSIONER VOSS: Okay. Thanks.

Yeah, Bob.

MR. SKOW: I made an observation, I just wonder, just a minor suggestion, this working forum, shouldn't it maybe be called health insurance and health care services cost reductions? That's what the legislation kind of says as well. I just wanted to make that clarification.

INSURANCE COMMISSIONER VOSS: Yes. Your point is well taken.

MR. TEELING: I have some comments now.

INSURANCE COMMISSIONER VOSS: Yes, Joe.

MR. TEELING: Just-- I think the purpose and scope of this group is a little more focused in the health and wellness, and all that. I don't disagree with any of that. Certainly it's something

we should look at.

Though you may not know, the health care commission, and I'm not saying the exact name, we have a new work group called Work Group IV that's literally going to take up this issue. We're going to have, we hope, 16 presentations over the next couple of months. Almost all Iowa-based firms that are doing pretty advanced work in this area have got some concrete results.

I just want your group to know that that group exists and is going to be working on that. If you want to tap into it, or learn more about it, or stay tuned and apply some of what we learned to what you would like to do here, you're welcome to.

MS. FREEMAN: Joe, is that a state group? Is that through your insurers or is it through the State of Iowa?

MR. TEELING: Right. The Legislature has appointed a commission.

MS. FREEMAN: Okay.

MR. TEELING: The commission has broken itself down into a work group, and this is a new work group that's going to be looking at this area. It will report its findings back to the commission, and then the commission will make recommendations to the

state. That's the processes that have occurred over the last several years.

INSURANCE COMMISSIONER VOSS: I think ours was really, to be fair to Representative Petersen, was not looking at all of the underlying health care costs like I think your group is. I think she was really looking at some of the more administrative costs that drive people nuts, whether you're a provider, or small employer, when you're filling out forms. We tried to address some of them. She was hearing some rumblings about that during session. I mean, I think the point is well taken, and we need to be mindful of those as well.

I'm sort of hearing, there's some definite issues here about precertification, claims forms, kind of the eligibility determinations. I have credentialing in there. Maybe it would be good to maybe drill down on those a little more and maybe have some real groups that deal with those on a regular basis, probably more the docs.

As I look at all of you, all of the provider community, maybe we do need to get the medical--the Board of Medical Examiners to come in and maybe they can be a part of this equation.

Is there a way we can get them involved? I

don't really know. That's kind of out of my realm. Thank God I don't regulate that.

Then find out about the HIPAA issues with EOBs, and some of that. Is there a barrier there that we just have to--need to get over. Are there other issues that maybe we haven't tapped into or you have concerns about that we need to do some more review?

DR. REITER: There is one thing that I overheard, it's in terms of billed charges and discounted charges. It had to do with workers' compensation. I heard him say usual and customary. Well, usual and customary hasn't been allowed in anything else for, I don't know, 15 years. A long time. That's an inaccurateism that likely complicates payment in that whole system and may need to be looked at.

INSURANCE COMMISSIONER VOSS: I don't know, is that just in workers' comp? What happened in the audit?

MS. ROBINSON: They do have similar, usual and customary.

DR. REITER: What does that mean?

MS. FREEMAN: The doctor charges.

DR. REITER: Well, charges are--

MS. ROBINSON: It's not called exactly that, but similar.

DR. REITER: Charges are fiction.

INSURANCE COMMISSIONER VOSS: That may be something else we have to look at. That's a side issue too. Although, trust me, workers' comp did not come up in any discussions with Representative Petersen. I'm not sure I want to open that door. Workers' comp is a whole different--I mean, I can certainly pass that along to other people.

MS. FREEMAN: We've been there.

DR. REITER: Perhaps just the idea, the notion of usual and customary that's in the law is no longer an applicable phrase and the language should be modernized.

MR. TEELING: That's always been very problematic.

INSURANCE COMMISSIONER VOSS: All right. Here's what I'm thinking. Why don't I look at a copy of what you all, this good stuff you talked about. I'll kind of go through those, look at those four topics, and maybe find a smaller group to work together. We'll send out a copy of the Court Reporter's notes so you can remember what we've said. We'll e-mail that.

Let me just decide if we're going to get back together. I'll do a little research on some of these issues and see if there's another group that needs to meet. We obviously have to have something by November 15th. We're going to be a little busy in this office before November 15th. I will be honest with you, it will be amazing if we get anything done by November 15th, but...

MS. FREEMAN: Commissioner, two other just thoughts.

INSURANCE COMMISSIONER VOSS: You don't have to call me Commissioner.

MS. FREEMAN: Well, then I might leave.

I really am wondering what the administrative simplification provisions of the health care--we may have things that we can build upon in Iowa in looking at that and maybe even some grant dollars.

The second thing is when you are--as you move toward exchanges, my recollection is there's language in there about uniform forms, uniform practices, those may be practices or provisions that could apply beyond just the exchange setting.

INSURANCE COMMISSIONER VOSS: Right. In my conversation, we applied for the grant, for the

exchange grant. The Department of Public Health actually filed the application. We figured this first year, should we get the money, is really going to be spent talking a lot about the technology behind the exchange.

I mean, we're not--I don't want anybody to believe that a year from now we're going to know exactly what it looks like or what it's going to be. Just listening to the Medicaid folks, and Jennifer Remere explained to me that they think probably Medicaid is going to have to build a whole new system, it's such a patchwork.

I don't know if any of you have seen the application grant, obviously you have a lot of time on your hands if you have, but it contemplates six public meetings in the next year and a group, such as you, to be sort of an advisory group to talk through how you would build this electronic exchange system.

I'm guessing a lot of that would be applications, everybody has to be on the exchange, and how it would interface with what we currently have and moving everything to a new system. I'm guessing simplification would be part of that. Obviously the people that are going to have to use that aren't rocket scientists, like me. That will

all be kind of in the next year we're going to be doing a lot of discussion.

DR. REITER: Since you have, it sounds like you have enough input to get your report this year, and the requirement is annually, perhaps if you have a meeting earlier next year you could follow up on some of this information, and then if there's more work that needs to be done, there would be time to do it.

INSURANCE COMMISSIONER VOSS: Right. And we can meet--this doesn't say we only meet once, we can meet monthly if you would like to. Just what you would like, another meeting.

I think actually with this, and then we have this--we're going to have this other review on cost drivers, you're going to have Legislature, there's going to be a lot of groups working on this. It probably wouldn't hurt if we all met together at some point.

DR. REITER: There's not a room big enough.

INSURANCE COMMISSIONER VOSS: There's not a room big enough? Well, I thought there was going to be more people here today. Maybe they figured you would all solve it for them.

I'll put that all together and then probably

get back in touch with you about maybe a smaller group, and then maybe just having a meeting with some of the groups that you mentioned that weren't here today, including the Board of Medical Examiners. Maybe we'll get Wellmark here too to talk about some of this.

Did everybody sign in?

Okay. Thank you.

(Hearing concluded at 2:57 p.m.)

C E R T I F I C A T E

I, the undersigned, a Certified Shorthand Reporter of the State of Iowa, do hereby certify that I acted as the official court reporter at the hearing in the above-entitled matter at the time and place indicated.

That I took in shorthand all of the proceedings had at the said time and place and that said shorthand notes were reduced to typewriting under my direction and supervision, and that the foregoing typewritten pages are a full and complete transcript of the shorthand notes so taken.

Dated at Des Moines, Iowa, this 22nd day of September, 2010.

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