SOUTH DAKOTA
STATE MEDICAL ASSOCIATION
Values. Ethics. Advocacy.

SDSMA Comments on Zaniya Project Task Force Final Report

SDSMA Zaniya Project Task Force Members

Kevin L. Bjordahl, MD

James A. Engelbrecht, MD

Barbara A. Smith, CEO

South Dakota State Medical Association
PO Box 7406
2600 W. 49th St.
Sioux Falls, SD 57117-7406
605.336.1965
www.sdsma.org

South Dakota State Medical Association Comments on Zaniya Project Task Force Final Report

The 1,600 physician and medical student members of the South Dakota State Medical Association (SDSMA) are dedicated to improving the health of all South Dakotans. Since 1882, SDSMA has worked to advance professional standards, enhance the public health and enable physicians to concentrate on caring for their patients.

We express our sincere gratitude to Governor Mike Rounds, Lt. Governor Dennis Daugaard, Senator Tom Dempster, Representative Joel Dykstra, as well as the South Dakota Legislature, cabinet members and staff for the leadership, financial support, and hours of research and analysis that went into the Zaniya Project Task Force. As physicians, we know the difficulty that often comes with accurately diagnosing disease and devising the appropriate treatment regimen. We encourage our state's political and economic leaders, physicians and others in the health care industry, and every South Dakotan to read the Zaniya Project Task Force Final Report and discuss its recommendations with your physician, your legislators, your friends and your colleagues.

As physicians, our primary concern is promoting health. We stand for and support what's good for the health of our patients, what's good for the physical and fiscal health of South Dakota, and what's good for the health of the health care system. The Zaniya Project Task Force brought together leaders and decision makers to search for common ground. We didn't agree on all of the solutions, but we did agree on the need to treat the ailments plaguing our health care system and move forward.

The SDSMA believes that all South Dakotans must have access to affordable, high-quality health care and an appropriate medical home. South Dakota physicians support the task force recommendation for an employer assistance program to help make coverage options available. We believe that physicians, other health professionals, employers and payers need to work together to devise and test initiatives to require health plans to offer coverage that is more broadly accessible, affordable and portable — including a basic benefit plan (and basic benefit package options using health savings accounts, preventive care coverage, and catastrophic care coverage) that is adequate to protect health and could meet the needs of targeted employee groups; a fairer system of spreading risk and sharing cost rather than the current system that seeks to avoid the groups of people that generate the greatest cost; and additional, more affordable insurance continuation options.

We are concerned that a preliminary recommendation to establish a basic benefit plan was not approved for inclusion in the final report. A standard set of health services essential to protect health should be established as the required coverage for all individuals. Services beyond the standard set should be available in a competitive market but would not be subsidized by the broader community.

The preliminary recommendation to institute a financial responsibility standard for health care services was amended to include a recommendation to examine a standard for personal responsibility. The SDSMA believes that individuals must take more responsibility in obtaining insurance, for financing their employer-provided or individually owned health insurance products, and for using the system wisely and resources judiciously. It is our understanding that development of a basic benefit plan would be part of a workgroup review of ways

to encourage personal responsibility.

Physicians do not support the recommendation in the final report to create a risk pool which would allow health plans to continue denying coverage to those who need it the most. The ideal health care system should require that health insurance is available to all South Dakotans and ensure affordability through subsidies for persons with limited financial means. If the state's risk pool is expanded or a new one is created, the current funding method is not acceptable.

The financing mechanism used to fund these programs must be broad-based and directly and adequately fund the costs of medical care provided. The subsidies provided by lower reimbursement and the resulting market disadvantages are now borne disproportionately by certain physicians and other health care providers who provide care to risk pool enrollees. Continuing to rely on this funding mechanism, or expanding this type of program, would exacerbate these problems. Therefore, the SDSMA opposes the expansion of coverage through a risk pool unless a new financing method is developed and government payment policies are revised so that reimbursement is adequate to cover the cost of providing care.

The SDSMA supports efforts to enroll all eligible persons in existing public programs and extending access to private health insurance using Medicaid-funded premium subsidies for low-income parents and childless adults. While not a task force recommendation, we believe the state should explore the possibility of blending Medicaid funds with employer subsidies to purchase affordable health insurance for low-income uninsured workers.

For these public-private partnerships and innovations to work, we must impose no additional burdens on health care financing, including no taxes on patient care which would drive costs higher or be an unrecoverable expense that would force South Dakota physicians out of practice and worsen our state's access-to-care problems.

The SDSMA supports expanding Medicaid and SCHIP eligibility for children and pregnant women. However, government should buy health care services on the same basis as the private market. It does not cost physicians less to provide care for individuals covered by Medicaid or SCHIP than it does to provide the same care for those with private health insurance. Government should not set arbitrary prices that may be less than actual cost. The result is a shift of costs onto other payers. Therefore, physicians believe that any further expansion of Medicaid or SCHIP should be conditioned on enacting competitive physician reimbursement rates. Medicaid payments are not adequate to cover the cost of providing services. Many physicians' practices, which are small businesses, cannot maintain their viability in the face of increasing expenses. Physician participation in Medicaid is dropping and resulting in access problems in many areas of the state.

South Dakota physicians support creating value in the health care of our patients, eliminating excess administrative costs, using health care information technology to improve the quality of care, and investing in prevention. We urge the state to pursue efforts to simplify billing for our patients. We also support the task force recommendation to develop a plan to bring interoperable electronic health records to all physicians' practices and encourage public/private sector collaboration on a plan that will make developing and using health information technology affordable.

The SDSMA supports continued efforts to ensure access to primary and preventive care. South Dakota must build an adequate, home-grown sup-

ply of appropriately trained physicians to help meet the increasing demand for physician services, especially in rural areas. State funding for medical education and expanding class size at our medical school should be increased. Clerkships in rural medicine and loan-repayment/forgiveness programs for students who practice in underserved areas of the state should be strengthened.

Additionally, physicians believe that cost-control efforts should be concentrated where the costs actually are, which is different from current efforts that focus on lower-cost areas. Health care spending is highly concentrated in a small percentage of patients. The greatest opportunity for cost savings is in better management of chronic diseases, especially those that result in hospitalization. The savings opportunities in the outpatient setting are more limited. Savings are possible by helping physicians to provide clinically appropriate medical care based on sound medical science and promoting a team-based approach to safe and effective health care delivery. Again, we support providing an appropriate and enduring medical home for every patient, not just uninsured patients as referenced in the task force report.

South Dakota physicians also believe we need to increase prevention and empower patients to take more responsibility for their health. At least 50 percent of health care expenditures are lifestyle related, and therefore, potentially preventable. It is incumbent upon individuals, physicians, and other health care professionals, employers, health plans, and the government to focus on wellness and prevention. We must continue efforts to combat obesity and tobacco use.

The SDSMA also supports promoting federal policies to improve the health status of American Indians, maximizing existing resources for access to health care for American Indians, and seeking creative solutions to improve American Indian health care options. We believe that efforts should be made to bring together non-Indian Health Service and Indian Health Service physicians to promote quality of care issues.

The 1,600 physician and medical student members of the South Dakota State Medical Association are dedicated to achieving meaningful health care reform that will result in empowering patients to make choices and assuring that physicians are able to practice clinically appropriate medical care that results in healthy South Dakotans.

P. Kenneth Aspaas, MD
President
South Dakota State Medical Association

South Dakota State Medical Association
PO Box 7406
2600 W. 49th St.
Sioux Falls, SD 57117-7406
605.336.1965
www.sdsma.org

3900 W Avera Drive
Sioux Falls, SD 57108-5721
(605) 322-4700
Fax: (605) 322-4799

www.avera.org

Attributed Comment on Zaniya draft final report, Recommendation #1:

It has been a pleasure to serve on the Zaniya Project Task Force these past six months. The Task Force has had to opportunity to view new data regarding the uninsured and formulate recommendations which can go forward as a general report from the group. The report recognizes that not every member of the Task Force agrees fully with every recommendation. As a member of the Task Force I am posting this comment as an indication of my general support for the recommendations. However, there are some specific comments I would like to post with regard to the plan recommendation to create a risk pool for the uninsurable in South Dakota.

Presently the South Dakota Risk Pool for HIPAA individuals and persons in "closed block" individual health benefit plans covers nearly 700 persons. The premium paid by individuals enrolled in this risk pool is set at 150 percent of average premium amount paid by individuals enrolled in the three largest individual insurance plans in the state. In addition to the premium paid by individuals, the plan is funded with a $.25 per member per month assessment on all persons enrolled in individual and group health insurance plans in the state. Also, under this plan the providers of health care are paid at rates equal to 135 percent of the South Dakota Medicaid rate, an amount substantially below market rates.

The Zaniya Project Task Force did much of its recommendation development through work groups, one of which was the Insurance Workgroup that formulated the recommendation for the creation of a risk pool for the uninsurable in South Dakota. This Workgroup reported that the uninsurable risk pool could include up to 5,211 individuals based on the updated survey of the uninsured in South Dakota. The Workgroup also reported that based on the current risk pool experience, the shortfall between claims and experience in funding the uninsurable risk group could be as high as $18,000,000.

Given one of Governor Rounds' stated operating principles for the Zaniya Project, "first of all, do no harm," I believe the following considerations are important:

- The size disparity of the proposed risk pool. (5,211) compared to existing risk pool (< 700) makes it important that the new risk pool be a separate pool so as to not threaten the viability of the existing risk pool.
- The existing assessment formula places the burden on those insured in private individual and group health insurance plans. On a per-capita basis the assessment needed to cover the 5,211 individuals would approach nearly $2.00 per member per month, adding to the cost of insurance for individuals and some employers of those persons already insured.
- It is likely that many of the persons who are uninsurable will have difficulty paying premiums set at 150 percent (or higher) of the individual insurance market. Consideration may need to be given to a premium subsidy for those individuals, adding to the shortfall of $18,000,000.
- Over time, increased costs to employer and individual insurance plans may result due to the large increase in the number of persons covered by a government program with provider reimbursement rates well below market rates.

There is no doubt that it is important to include the uninsurable population in the actions taken in response the Zaniya report if the effort is to be successful. Harm to specific components of our state's economy or consumers can be moderated by recognizing the importance of acting on the set of Zaniya recommendations as a package, and not selecting specific recommendations and discarding others. Most important, however, to do no harm, the package of Zaniya recommendations needs to be financed with a broad-based financial strategy and fair payment for services, which assures no one is getting a free ride and that no particular segment of society is disproportionately disadvantaged when implementing these recommendations.

Jean M. Reed
Senior Vice President
Avera Health

Recommendation #5. Establish a Basic Benefit Plan

Because Recommendation **#4. Institute a Financial Responsibility Standard for Health Care Services** was originally struck down by a close vote (19-15), Recommendation #5, which required a financial responsibility standard, was also struck down. However, at the end of our final Zaniya Project Task Force meeting on September 13, 2007, #4 was reconsidered, and a revised recommendation was passed. During the process of reconsidering #4, Representative Dykstra asked the Chair to also reconsider #5. The Chair ruled that that could be discussed after Recommendation #4 reconsideration was completed. By the time action on #4 was completed, the group was already one-half hour beyond the original proposed adjournment, and the meeting was adjourned without addressing reconsideration of #5. Thus, reconsideration of **#5. Establishing a Basic Benefit Plan** was never addressed. As establishing a Basic Benefit Plan is essential to any health reform and because the major reason it was not reconsidered was due to the time pressure of adjournment and/or oversight of the Task Force, I believe it is vital that the Task Force be allowed to reconsider this recommendation. Such action could be accomplished by an email or conference call vote prior to completion of the final report.

Because a basic benefit plan is central to any health insurance reform program, I believe it must be addressed as a major piece to any proposed reform legislation. Affordability will be critical to all insured, as well as the currently uninsured. The cost of insurance has gone through the roof and is increasingly unaffordable for the majority of US citizens and a drain even for the upper class. For example, the average monthly premium paid by those employees who are fortunate to have an employer-provided program has increased from $135 in 2000 to $248 in 2006 for basic family coverage.[1]

The increase for individual policy holders is even worse. For example, a fellow SD Senator who has a basic policy has experienced rate increases from $325 to $650 per month in the last four years. Many legislatures, including North Dakota's, which otherwise has similar reimbursement daily rates to South Dakota, provides every legislator the option to buy the same quality of insurance and state match as state employees. As I am among the few legislators who is already receiving Medicare, this does not directly affect me. However, it does affect the vast majority of legislators who serve in the Senate and House. If we, the South Dakota Legislature, provide a good basic benefits policy to our state employees and retirees, it is only fair that legislators should similarly qualify.

---

[1] "Insuring Poor Children," *The Washington Post Weekly Edition*, September 3,-9, 2007: 29.

Therefore, I propose that any SD insurance reform also include provision for all legislators with the same benefits package and personal matching of state employees.

Sincere regards,
Tom Katus, SD Senator, District 32

I do have a comment of clarification relative to my anonymous comment from the worksheet. My original comment really dealt with recommendation numbers 12, 13 and 14. It was included in recommendation #12 in the power point presentation. The comment stated something to the effect that "We are currently graduating 70 Doctor of Pharmacy students from SDSU yearly " and that they could be part of a solution for improving disease state management by collaborating with physicians in practices such as mine here at Medical Associates in Pierre. The primary impediment to this occurring right now is a lack of provider status in State and Federal statute. Even though State Law currently authorizes collaboration in this type of setting between physicians and pharmacists, these activities are few and far between because of the lack of provider status, thus the lack of reimbursement between Medicare/Medicaid/Private Insurance companies and the pharmacists. Bottom line…we have a bunch of over-educated, eager, young Pharmacist-clinicians who are trained to do the very thing that we are talking about here (disease state management) stuck behind prescription counters when they should be working right alongside overworked physicians in these underserved areas trying to help with their workload.

I think that the comment best stays at Recommendation #14, but the tentacles obviously do extend to #16 with regard to recruiting/retaining health professionals and encouraging physician-patient relationships at the primary care level. My comment really never had anything to do with "students". Rather, it deals with the young graduates that we are pumping out and losing to other States due to lack of satisfying job opportunities here in our communities.

Let me know if you need additional clarification on this, and again, thanks for your contribution.

Steve Lee, Pharm.D.