Committee Minutes:

Health Care Task Force

House Majority Caucus Room

State Capitol, Boise, Idaho

Tuesday, August 19, 2003

9:00 a.m.

Corrected Minutes

The meeting was called to order at 9:00 by Cochairman Representative Bill Deal. Other Task Force members present were: Cochairman Senator Dean Cameron, Senators Joe Stegner and Fred Kennedy and Representatives Max Black, Margaret Henbest and Kathie Garrett. Senator Sheila Sorensen, Senator John Goedde and Representative Gary Collins were excused. Staff members present were Caralee Lambert and Toni Hobbs.

Others present included: Bob Seehusen, Idaho Medical Association; Julie Taylor, Jack Myers and Dave Hutchins, Blue Cross of Idaho; Jack Jones, AARP/Council on Aging; Norm Varin and Tim Olson, Regence BlueShield of Idaho; Elwood Kleaver, Primary Health; Jim Baugh, Co-Ad; Mike Brassey and Vic Moretto, St. Luke's Regional Medical Center; Bonnie Haines and Steve Millard, Idaho Hospital Association; Ken McClure and Molly Creswell, Givens Pursley; John Summerton, Strategic Employer Benefits; Eileen Farley, National Alliance for the Mentally Ill; Phyllis Stephenson and Joan Krosch, Department of Insurance; Woody Richards, Moffatt Thomas; Steve Tobiason, Idaho Association of Health Plans; Pam Ahrens, Department of Administration; Chris Pickford, Employers Health Coalition of Idaho; Andrea Mihm, Sullivan and Reberger; Tony Poinelli, Idaho Association of Counties; and Julie Robinson, State Planning Grant.

After a motion from **Senator Stegner** and a second from **Senator Kennedy,** the minutes from the July 29, 2003 meeting were approved as written.

Mr. Dave Hutchins, Blue Cross of Idaho, was the first speaker. He discussed proprietary information regarding the company's observed and projected trend and rate increases in the individual and small group areas of insurance. He stated that they have projected a growth rate of about 15% for the combined medical and drug trend. **Senator Cameron** asked if, since the rates have already been established for September, 2003, the company does a study after the establishment of rates to determine trend and market conditions. **Mr. Hutchins** answered that this is done. He continued by stating that the trend applies to future rates because they have to estimate how much claims costs are going to go up in the future. That estimate is currently 15% based upon past history.

Senator Cameron asked how trend is determined and why there appeared to be a downturn from November, 2003, to December, 2003, that was not reflected in the rates. **Mr. Hutchins** stated that this was the first downturn they had seen for quite some time. The company looks at the cost per member per month over time and tries to relate that back to reimbursement levels to physicians. They also look at national surveys and other Blue Cross plans trends. The profitability and success of the company depends upon getting this number right.

In response to a question from **Senator Stegner, Mr. Hutchins** defined trend as medical cost increases from one 12-month period over the next 12-month period that are billed to the insurance company and that the insurance company owes to providers.

Mr. Hutchins continued by stating that they did not recognize that the trend was increasing because they review this after rates are set. So instead of staying even with trend, the company was giving rate increases at the 10% level while the trend was climbing up to 16%. Once they recognized this, in order to get the rates into line, they anticipate having rate increases in the small group line of business between 20% and 25% through the end of this year. At that time the rates will drop to the 15% level and match trend. **Senator Cameron** clarified that it is not the rates that will drop, but rather the percentage of the increase. The best scenario projected would be rate increases of 15%. **Mr. Hutchins** agreed.

Representative Henbest asked why Blue Cross raised the rates 23% in October, 2002, even though the projection trend was at 15%. **Mr. Hutchins** answered that this was to make up for when the rates were 10% and trend was 15%. The rates are set on projected costs and then they adjust when they get the actual numbers.

Representative Deal asked if the company is also seeing more utilization of services. **Mr. Hutchins** said yes. Technology is a big driver for this. The total cost for MRIs, CAT scans and other technologies has been going up at 30% a year. People are substituting more expensive services for cheaper services.

Mr. Hutchins continued by stating that the rate increase for the individual market is much higher than for the small group market. The increase in this market is nearly 30%. **Representative Henbest** and **Senator Stegner** asked **Mr. Hutchins** to redo the graphs with correct dates and to include the information from April, 2003, so they could get a better grasp of the actual numbers.

Senator Cameron requested that the factors used to determine trend also be included on this graph.

Senator Cameron stated that in his opinion, when companies find that their projections are off by 5% to 7%, it would be wiser to spread the increases out over a couple of years instead of trying to make it up all at once. **Mr. Hutchins** said that is a choice the companies make every time they are faced with this type of a situation. Most organizations he has been with have the philosophy that it is better to get to the correct rate level right away rather than chasing it for several years.

Representative Black asked if there is any evidence that the high risk pool has had an impact on slowing the rate increases down and if this could be graphed. **Mr. Hutchins** clarified that the high risk pool was established as a sharing mechanism to protect one company from having to bear a large claims burden. It was not intended to keep rates low.

Senator Cameron asked to what extent the uninsured population affects trend. **Mr. Hutchins** answered that the uninsured population affects trend through the amount of uncompensated care given by providers. These costs then have to be passed on and in some cases they are passed on to the insured population. The greater the uninsured population, the more costs that are passed on to the insured. Also, if healthy people choose to remain uninsured, the remaining insured population is sicker, so the insurance rates are higher to cover the costs. This would kick up trend. Unfortunately, there is a cycle that as rates go up, more people become uninsured, and consequently the rates are increased even further.

Representative Henbest asked why the rates were set so low in October 2002, or so high in October, 2003, if Blue Cross thought trend was going to be 15% in October, 2001. She also asked how the company can justify these large rate increases from a regulatory standpoint. **Mr. Hutchins** answered that when the company sets rates, it looks at the prior 12-month period. They do not give the rate increase that equals trend; instead, they give a rate increase that, given trend, will give the company the profitability it wants for that block of business.

Mr. Jack Myers, Blue Cross of Idaho, was introduced to discuss national trends. He stated that the median observed trend overall has climbed from 12.1% for the 12 months ending December, 2001, to 13.3% for the 12 months ending December, 2002. This is the actual underlying medical

cost trend. He explained that cost actually includes technology shifts as well as price increases within the provider community.

Mr. Myers stated that there is a perception that the health care dollar is split, with about half of it going to medical care, one quarter going to business expenses of the insurance company, and 19% to 22% as profit. In actuality, for the entire industry, medical claims costs are 85.7%, administrative costs are 11.6%, and the insurance industry as a whole makes about 2.7% in profits. The aggregate of all Blue Cross/Blue Shield plans is 86.5% for medical claims, 11% for administrative costs and profits of about 2.5%. He added that at Blue Cross of Idaho in 2002, there was an underwriting gain of 1%. Net financial gains for the same year were also close to 1%.

Senator Stegner asked what response Blue Cross expects from members regarding the 30% rate increase that **Mr. Hutchins** discussed. **Mr. Myers** said they do expect some members to drop coverage, but they have observed a slight increase in membership in the individual product market this year. Their goal is to stabilize the rate increases so this type of increase does not happen again. He added that this loss of membership is not thought to be a factor this year in rate increases.

Senator Cameron asked if the index rate that is filed with the Department of Insurance was reflected in the rate increases in the individual market. **Mr. Hutchins** stated that the index rate would follow the rate increases very closely. **Senator Cameron** clarified that Idaho statutorily caps rate adjustments at 15% plus trend.

Norm Varin, Regence BlueShield of Idaho, discussed the large rate increases in the small group market (2 to 50 employees) and the individual market. He stated that Regence is experiencing the same health care trends noted by Blue Cross. The company's aggregate overall trend is about 15% on the average. The following are a few items that Regence perceives to be cost drivers:

- Fraud
- Treatment
- Obesity/Lack of Exercise
- HIPPA expenses
- Privacy issues
- Need to update or replace facilities
- New technology

The average rate increase for the small group market for Regence has been between 20% and 30%. This is a correction for this year to catch up with premiums that were too low. In January, 2004, rate increases will be between 15% and 25%. The individual market will increase 30% to 40% and in 2004 will be 20% to 30%.

Mr. Varin noted that Regence is the largest insurance carrier in the state for individual insurance. They are committed to providing insurance in the individual market for many years but since 1996, the company has lost $32 million on all of their individual business. This is over half of the underwriting loss for the company. It is not healthy for this line of business to continually be subsidized by other lines of business and they are trying to correct the rates so the individual line of business can stand on its own.

They are also introducing a new product in the small group market called "Regence Select" that creates more options with benefits that offer lower rates. This product also exposes the member or the employer to more of the cost of the health care.

Mr. Varin added that Regence did receive many questions due to the large rate increases. As a result, the company felt that the community needed to receive information about what was driving the cost of health care and what they were doing about it. He distributed a brochure entitled "*Why Does Health Care Cost So Much?"* that is available from Regence.

Representative Henbest asked if Regence would submit to the Task Force the same information that Blue Cross presented, specifically showing information about observed and projected trends as well as rate increases. **Mr. Varin** said they would provide that as proprietary information. **Senator Cameron** added that the method by which Regence calculates trend should also be included in the information. **Mr. Varin** stated that regarding trend, the company looks at the observed trends with a 3-month to 4-month lag time. He would include that in the information provided.

Senator Cameron asked if Idaho's trend line is different from the other states with which Regence is affiliated. **Mr. Varin** said he had not seen that information but would gather it for the Task Force. **Senator Cameron** commented that he thought Utah's trend was lower and, if that is true, he would like an explanation regarding why it is lower. He added that the Task Force would also like information regarding how to prevent these types of rate increases in the future.

Representative Henbest asked whether the insurance companies are moving toward evidence-based decision making from a medical practice standpoint. **Mr. Varin** said that he is not aware of any specific efforts on their part at this time. He added that they are considering possibly looking at using tools that measure the efficiency of providers in the future.

Senator Stegner asked what the company anticipates the impact of these huge rate increases will have on their membership and what that means for individual policies with Regence. **Mr. Varin** stated that they are committed to the individual market in Idaho. However, if it becomes a financial problem for the company, it will have to consider what to do. He distributed two proprietary charts describing monthly enrollment figures for small employer and individual

products. In spite of the huge rate increases, he said, they are showing increases in enrollment. He added that enrollment in the small group market should also continue to show increases due to the new product they are introducing. In response to a question from **Representative Henbest, Mr. Varin** stated that the large increases will have an impact but changes take time to develop. It could take six to twelve months to see what effect these increases have.

Senator Cameron asked if any groups are changing product design as a result of these increases. **Mr. Varin** answered that 70% to 80% of the members in the small employer market are changing products at renewal. This is mainly a result of changing deductibles. He has not seen the numbers on the individual market but he has seen a migration over time from the lowest copay to the higher copay products. He has not seen a large number of people doing this but he will get the numbers for the Task Force members.

Mr. Varin continued by stating that in the 1970s, the average percentage of the health care bill that members paid was about 50%; today that number is about 14%. In many ways, the insured population has shielded itself from the actual cost of health care. There is some speculation that there will be a shift back to higher copays and more responsibility on the part of the member to pay for health care.

Elwood Kleaver, Primary Health, was the next speaker. He agreed with the first two presenters regarding the cost drivers of health care. He added the following as additional cost drivers:

- Co-insurance and deductible leveraging. Costs are going up while deductibles are staying at the same level. This is an added cost being passed on to the insured.
- Direct consumer marketing.
- Patient demand for services.

He added that when he refers to technology and new procedures as cost drivers, he is referring to additive procedures, not replacement procedures.

Mr. Kleaver continued by stating that another cost driver is government regulation, or HIPPA. Every insurance company and every major provider in the country is dealing with this today. It is actually costing more than the Y2K information upgrades. Aside from the cost itself, information technology departments are spending a majority of their time working on these projects to the detriment of other projects.

Representative Henbest requested that **Mr. Kleaver** provide information to the Task Force regarding trend and rate increases.

Mr. Steve Millard, Idaho Hospital Association (IHA), spoke to the Task Force next. He stated that the IHA understands that the premium increases are directly related to the increases in health care costs. He agreed with the cost drivers that were discussed earlier and stated that the IHA's list of cost drivers also includes:

- Costs associated with the uninsured population
- Medical technology
- Work force issues
- Patient demand (particularly with aging baby boomers)
- Pharmaceutical costs
- Regulatory compliance
- Under reimbursement to providers
- Complex payment systems
- Malpractice insurance
- Limited service hospitals --This is a relatively new phenomenon whereby hospitals are being built to perform specialized procedures such as orthopedics, heart surgeries and obstetrics. Most of these services are the only services on which a full-service hospital is able to get any margin. When these services go to a free standing center that offers only that service with no emergency services and is not open 24 hours a day, services and equipment are duplicated and profitable services leave full-service hospitals.
- Rising health insurance costs of hospital employees.

Mr. Millard reminded the Task Force that doctors, not hospitals, admit and discharge patients.

Representative Black stated that fixed reimbursement rates set by insurance companies, not just Medicare, make the individuals responsible to pay for more of their care. He asked whether this would cause more people to drop coverage. **Mr. Millard** answered that this is a potential problem in the future. The original idea was that providers receive a fixed payment for taking care of someone. The more efficiently they do this, the more money the provider makes on the procedure. If the doctor is inefficient, he may lose money on the procedure. The problem is that Congress and the federal government continually change the requirements just as providers learn to handle the system. The fixed payment system of reimbursing hospitals makes sense if it is done based on realistic data that is updated in a timely manner. This does eventually come back as an increased cost to the insured.

Representative Henbest commented that in talking to a nursing administrator at a local hospital she was informed that current hospital beds and wheelchairs are not large enough (by about 100 pounds) for the average patient. This is another factor in increasing costs to hospitals as hospitals have to replace beds and wheelchairs to accommodate the larger patients.

In response to a question from **Representative Henbest, Mr. Millard** commented that hospital expansion costs are increasing in Idaho. This is occurring in mostly high growth areas because they need to keep up with demand. A few years ago, when St. Luke's was remodeling and

building their Meridian facility, population projections showed that without these expansions the Treasure Valley would face a shortage of beds in 10 or 15 years. Another reason for the need for expansion is the shift from inpatient to outpatient care. Hospitals need updated facilities to handle the outpatient care. **Representative Henbest** stated that there was a concern that "if facilities are built, patients will come." She asked what drives utilization. **Mr. Millard** said that this is a concern but he is certain that beds are not being filled just because they are available. He noted that different sections of the country have very different concentrations of health care. Some areas, for instance, have high concentrations of orthopedic surgeons and thus a high incidence of back surgery.

Senator Cameron asked to what extent cost increases are being driven by competition between hospitals. **Mr. Millard** said that was a tough question to answer. Health care competition is not the same as competition in other businesses. The problem with hospitals having to keep up with each other in technology is the reimbursement system. Services follow the money.

Senator Cameron asked what the state should do, if anything, to help hold costs down. **Mr. Millard** answered that there needs to be discussion among the provider community, payers and consumers to talk about what could be done. Personal responsibility for health care is a big issue and educating the public about this would be a good step. People should not be going to hospital emergency rooms for non-emergency procedures or care.

Mr. Millard said he would research the amount of indigent care costs that are written off by hospitals for the Task Force members, per a request from **Senator Cameron.**

Senator Stegner stated that he has concerns about the public perception that hospital competition is causing health care costs to increase. Some people perceive that hospitals have become greedy and that there are no checks and balances in the decisions they make in terms of expansion and facilities. These perceptions are enhanced by hospital advertising. In **Senator Stegner's** opinion, hospital advertising has no real purpose and would seem to be a waste of money. The perception in this case is that if a hospital has money to waste on advertising, they are making too much money. **Mr. Millard** replied that advertising is not a big cost driver but he understands the perception is out there. In response to his question to hospital members regarding what hospitals get out of advertising, the hospitals state that it is a competitive environment. While doctors, for the most part, direct where patients go for care, patients do have some say. Hospitals want to make sure patients know what services they provide.

He offered to have a hospital representative speak at the next meeting on the topic of advertising. **Senator Stegner** said that would be helpful. He added that it would be helpful for **Mr. Millard** to represent to the hospitals that there is some concern on the part of the Legislature regarding these issues and that efforts to demonstrate that hospitals are interested in cost containment and self-driven checks and balances on costs would be looked upon positively.

Senator Kennedy asked if there was any way hospitals could discourage doctors from using specialty hospitals. **Mr. Millard** stated that this was a very controversial issue between hospitals and the medical community. Some hospitals have made different demands on doctors who have ownership in these competing specialty hospitals in order for them to also practice in hospitals. Doctors often feel this is unfair. There are many ways to deal with this and several other states have already done so. Certificates of need are perhaps one way to deal with this. **Mr. Millard** added that the Hospital Licensing Act is very vague in its definition of a "hospital." He suggested that clarifying some definitions would be a step in the right direction.

Mr. Bob Seehusen, Idaho Medical Association, was introduced to continue the discussion on the increasing cost of health care. He said that physicians play a key role in the cost of health care. Nationally, about 20% of health care costs are for physician services. In Idaho, this figure is also about 20%. These costs account for about 6% of the Idaho Medicaid budget. Historically, physician fee increases have been very modest and most physicians belong to third party payer health plans. He explained that most physicians see Medicaid and Medicare patients even though these programs are controlled with fixed reimbursement rates. Last year, Medicare reimbursement rates to physicians were cut 5.4%; this year, the rates were increased 1.6%; next year, as of January 1, 2004, they are scheduled to be cut 4.2%. Medicaid follows the CPI. Last year, the Idaho Legislature made some adjustments to bring Medicaid rates in line with Medicare. Blue Cross did not have a fee increase last year for physicians; this year it increased 2.9%. Regence BlueShield's increase was 2.6% last year and 3.0% this year. While increases have been modest, costs to physician's offices based on specialties have been between 4% to 6% per year. Costs are related to personnel costs, nursing costs, office overhead, health insurance and medical malpractice. **Mr. Seehusen** clarified that cost shifts occur very seldom for physicians.

In regards to what physicians see as far as the trends in health care costs, **Mr. Seehusen** said that costs will always increase in the health care area. Two of the reasons for this are the aging population and technology. These two cost drivers will increase costs by about 4% to 4.5% per year.

Senator Cameron distributed graphs showing how various consumers' health insurance costs have increased over time, regardless of which type of coverage or what health conditions the consumers had.

Phyllis Stephenson, Department of Insurance, updated the Task Force on the status of a Department survey that was developed at the request of the Joint Legislative Oversight Committee. The survey monitors the effects of House Bills 750 and 780 (2000), which made significant changes to Idaho's laws relating to small employer and individual health plans. The survey results show preliminary findings with regard to enrollment, new business rates and risk classifications.

Ms. Stephenson explained that prior to HB750, the premium rate charges for a class of business could not vary from the index rate by more than 25%. The bill expanded the rate bands to 50%, which apply until July 1, 2004. The major change in premium rates was the result of a proposal by some insurance carriers doing business in Idaho. According to these carriers, expanding the rate bands would:

- Increase enrollment based on the carriers' ability to offer lower rates;
- Attract younger, healthier individuals at a lower rate; and
- Spread the risk wider as a result of enrolling healthier individuals.

The benchmark data gathered from the carriers includes:

Enrollment (1998-2001)

- Age distribution of insureds; and
- Total number of enrollees, individual and group.

Rates (1998-2001)

- Rate trends;
- New business rates; and
- Distribution of risk.

Ms. Stephenson displayed graphs showing overall enrollment and the effect the rate band changes have had on price and enrollment. Graphs also demonstrated the risk distribution for the small group and individual markets for the years 1998 through 2001, distributed into three risk classifications. These graphs are available through the Department of Insurance or at the Legislative Services Office.

The preliminary findings of the survey show that overall enrollment from 1998-2001 decreased by over 12,917. Most of the changes occurred in 1999 and 2000. Expanding the rate bands to +/- 50% had a slight impact on the base rate, in contrast to a considerable impact on the index and high rates. She stated that not all insurance companies are using the +/- 50% rate bands, so the 2001 information contains both +/- 25% and +/- 50%. This makes it difficult to say exactly what impact rate bands have had on rates.

Ms. Stephenson continued by stating that the small group risk distribution does not show much of an impact, but added that this could be misleading due to movement of groups in and out of the market in concert with economic times, and possibly how the overall group is rated with the addition of dependents. The enrollment in the High Risk Pool accounts for only 1.25% of the overall enrollment as of December 2001.

Ms. Stephenson explained how the rate bands work.

- At +/-25% with a base rate of $150.00:
  - The base rate would be $150.00
  - The index rate would be $200.00
  - The high rate would be $250.00

The total variation in this case between the base and high rates is 67% given the same case characteristics and benefit plan design.

- At +/-50% with a base rate of $150.00:
  - The base rate would be $150.00
  - The index rate would be $300.00
  - The high rate would be $450.00

Total variation between the base and high rate is 200% given the same case characteristics and benefit plan design.

Representative Henbest asked if the rate bands affect the base rate or whether the rate stayed the same because it is tied to the index. **Ms. Stephenson** said that not all carriers have the same base rate, so they can increase or decrease that base rate by 50%, but each carrier could have a different price. **Senator Cameron** clarified that the index rate is an average and from that index, by law, carriers can offer a discount of 50%. This creates a base rate. They can also surcharge 50% above that index rate, creating the high rate. It is from that index rate that companies apply trends to determine rate increases. **Senator Kennedy** said that it would seem from the information that the index rate is the important rate because it is the rate by which the insurance company determines what to charge. **Senator Cameron** said that was partially true, but that the published rates of insurance companies are usually the base rate. When a company takes an application, the person is put through underwriting to determine risk. Insurance agents have no way of knowing what a company's index rate is. There is a way to calculate this rate. From the

company's perspective, the index rate is used to apply the trend factors and this affects all the rate levels that are higher or lower.

Ms. Stephenson continued by stating that the preliminary findings regarding risk classification (with information up to 2001) show that with an overall decrease in individual enrollment, each risk classification (lower, middle and upper) decreases proportionately at comparable percentage rates. It was also noted that between 2000 and 2001, unhealthy individuals lapsed coverage at a rate higher than unhealthy individuals entered into coverage. Also more healthy people secured coverage than healthy individuals who were leaving coverage.

In summary, the preliminary findings show that overall enrollment, including large group, small group and individual, between 2000 and 2001, declined by 5,681 members. The individual market for the same years declined the most, down 7,549 members or 9% from 2000 to 2001. Expanding the rate bands to +/- 50% had a slight impact on the base rate (dollar amount) in contrast to a considerable impact on the index and high rates. The impact of this rate band expansion is not fully realized in the data that has been collected.

Ms. Stephenson reminded the Task Force that individuals who renew coverage are limited to the percentage change in new business rate (base rate) plus a limit of 15% for risk and any change in case characteristics (age or benefit plan design). New entrants, depending upon health, will receive a premium rate anywhere within +/- 50% of the index rate.

Representative Deal asked if the Department of Insurance had received current data from the insurance companies. **Ms. Stephenson** said the Department is in the process of gathering the 2002 information. **Joan Krosch** from the Department stated that to get current information, they would need to go back out to the companies and gather current enrollment numbers and build a new report. It would take about three months to complete this due to the fact that they are currently having system problems with the data collection. **Representative Deal** said that HB780 required that this information be provided to the Department and to the Legislature by insurance carriers and that he would like to see such a report. In response to a question from **Representative Black, Ms. Stephenson** said that providing this information is not necessarily difficult for the carriers. The main problem is due to the system problems. The Department is trying to make it easier for the carriers to download the data back to the Department without having it in spreadsheet format.

Senator Cameron stated that the purpose behind the expansion of the rate bands was to increase enrollment. He asked if there is any evidence that this has happened. **Ms. Stephenson** said that overall enrollment has decreased but the data is still in transition so there is no way to be sure. **Senator Stegner** added that according to the handouts provided by Regence BlueShield, a decrease in enrollment would seem to be what has happened.

Mr. Dave Hutchins, Blue Cross of Idaho, stated that the rate bands do provide some significant protections for the market as long as all of the carriers have to follow those bands. If this happens, the largest rate increase carriers can give is an increase due to trend plus 15%. Prior to small group rate reform, group rates could double or triple due to one very expensive member. Another protection rate bands provide is for the least expensive premium groups. This is because they do not stay the cheapest for long. Once a health condition occurs, with no caps on rate bands, companies could give these individuals substantial increases in health care costs. He stated that Blue Cross likes the rate bands and the +/- 50% because they feel it provides a more stable marketplace for the insured population. They are concerned that if the AHP legislation passes Congress, there would be a substantial contingent of entities who could do business in Idaho without state regulation. In the opinion of Blue Cross, the marketplace will return to a point where the healthiest groups receive an attractive rate for the first and maybe the second year, but rates will dramatically increase after that.

Senator Kennedy asked if Blue Cross had statistical data showing that the expansion of rate bands has attracted younger, healthier individuals. **Mr. Hutchins** stated that no study has been conducted showing the average age of those covered since rate band expansion took place. **Senator Kennedy** stated that one of the goals the insurance companies hoped would happen due to rate band expansion was that a greater spreading of the risk would occur. He asked whether there was any evidence that this had occurred. **Mr. Hutchins** said Blue Cross had not fully implemented the expansion of rate bands and that very few groups had reached the top end of the range. In response to another question from **Senator Kennedy, Mr. Hutchins** stated that Blue Cross has not seen any advantage to the people of Idaho as a result of the rate band expansion.

Senator Stegner asked whether it was the philosophy of Blue Cross or Mr. Hutchins' personal philosophy that the concept of insurance companies competing for healthy individuals is a bad thing. **Mr. Hutchins** said that compared to a fully unregulated market, that is the philosophy of Blue Cross. **Senator Stegner** commented that other companies, individuals or even the Task Force members might feel that increased competition for any level of client base is good for consumers and rate payers. **Mr. Hutchins** said that surveys of states where preregulation and postregulation occurred show that small group reform stabilized the marketplace. Even in the high trend conditions that exist today, small groups have benefitted.

Mr. Steve Tobiason, Idaho Association of Health Plans, stated that his organization supported the expansion of rate bands in 2000 and supported removal of the rate bands at some point in the future. The concept behind the expansion was that the +/- 25% attracted unhealthy people but healthy people were leaving the market because their premiums were increasing to cover the unhealthy. The idea of expanding the rate bands was to keep the healthy people in the market by keeping their costs down. At the same time, the thought was that in the individual and small group market, prices would go up at the high end and these people would need some other option for insurance to help spread the risk. This led to the creation of the individual high risk reinsurance pool.

The high risk pool seems to be working very well and has given the high end people that are being priced out of the market someplace to go. **Mr. Tobiason** continued by stating that according to what **Ms. Stephenson** discussed earlier, it appears that more healthy people are entering coverage than are leaving. That was the original concept. In his opinion, more data (at least 3 years) needs to be collected to see what the expansion of the rate bands has actually accomplished. The current data only covers up to 2001, and it is incomplete because not all carriers have implemented the +/- 50% bands. With the huge rate increases that are occurring, something needs to be done to keep the healthy people in the market.

Representative Henbest said that although some of the data is flawed or incomplete, it appears that enrollment has increased even though prices have increased. She asked where the unhealthy people have gone. In her opinion, these individuals have gone to the high risk pool or are making claims to the catastrophic fund. It would appear that expansion of the rate bands did not do anything. **Mr. Tobiason** commented that only a small amount of data has been received regarding the rate band expansion. He suggested waiting until more data is received. The Blue Cross data shows that their numbers are dropping but it takes time for these things to adjust. It is coming back up slowly. **Representative Henbest** said that it seems that healthier people have entered the marketplace but the end result has been a 30% rate increase. She asked if that increase would be even higher without the expansion of the rate bands. **Mr. Tobiason** cautioned that the expansion of the rate bands was not supposed to address the cost issue. Cost is driven by the cost drivers that were discussed earlier. The rate band expansion was intended to try to spread what people can be charged in different levels while trying to keep the rates low for the healthy people. Without healthy individuals in the marketplace, the industry will be in serious trouble.

Senator Cameron distributed rate band analysis charts comparing products and prices for new business for two major unidentified carriers. He stated that the charts showed rates both prior to and after the rate band expansion. He noted that it is difficult to compare the charts because product deductibles changed in some cases.

Representative Black commented that, in his opinion, it is very important that current data be collected by the Department and that the data be studied before the removal of the rate bands takes place. **Representative Deal** agreed, and said that a decision needs to be made in the next legislative session. He said that with the data collected so far, July 1, 2004 is too early for proposing the removal of the rate bands. **Senator Cameron** stated that the difficulty is that expanding the rate bands was not expected to lower premiums. The expansion was intended to keep the market viable by attracting healthy individuals. By lowering the base rate, he does not think this has happened. Before the rate band expansion, the rates stayed together; since expansion, the higher rate is much higher than the base or index rate, thereby forcing unhealthy individuals to pay much more or to leave the market altogether. If the law stays as it is after July 1, 2004, carriers will be allowed to charge whatever they would like for risks. He suggested one alternative would be to postpone that removal. In his opinion, even the healthiest rates are going up more quickly than what has been discussed today due to how renewals are factored in.

Representative Henbest said that expansion of the rate bands was a micro focus and is not going to solve all of the affordability problems that exist. Over the last few years, the affordability discussion has become more important. In her opinion, the Task Force needs to address this.

Senator Kennedy stated that he would like to continue with the +/- 50% rate bands until more data can be gathered and studied. He noted that so far there is no evidence showing that it has not worked. It would be inappropriate, however, to discontinue a program based on only one year's worth of data.

Mr. Varin commented that when the rate bands were expanded, there was a provision in law that still exists that said the change in renewal rates is tied to the new business rate. Failing to remove this provision, in his opinion, limited the ability for the low rates to become available. **Representative Henbest** asked why this argument was not made during the debate for the bill. **Mr. Varin** stated that it was included in drafts that were presented for the legislation but he did not know why it was struck from the final version of the bill.

Ms. Julie Taylor, Blue Cross of Idaho, explained that the AHP legislation that **Mr. Hutchins** mentioned earlier is a bill before Congress that would allow large associations to offer health care benefits to members. These associations would not be subject to regulation by the Idaho Department of Insurance and therefore would not be subject to rate bands while state insurance carriers would. If this legislation were to pass, Blue Cross would probably support elimination of the rate bands in order to give them equal opportunity to compete for business with these associations. **Senator Stegner** asked whether the bill would put associations on the same footing as large corporations such as Albertsons or Micron. **Ms. Taylor** said that it would. Currently, associations can offer health insurance. This legislation, however, is asking for an exemption from state regulation. Associations would therefore be regulated in the same way that large corporations are. The difference is that there are thousands of employee groups with very different characteristics. In response to a question from **Senator Stegner, Ms. Taylor** stated that these associations can currently be insured in one of the following ways:

- Contract with an insurance company and let the insurance company set the rates. This gives the risk totally to the insurance company.

- Self insurance. In this case, associations are regulated by the Department of Insurance in the state where they reside.

If this legislation passes, **Ms. Taylor** stated that associations will have the same options but without any state regulation. So far the bill has passed the House of Representatives and should be on the Senate calendar for fall.

Senator Cameron asked if Blue Cross thought that individual market enrollment has increased. **Mr. Hutchins** said that it is currently growing but over the last few years it has been decreasing consistently. **Senator Cameron** asked if new healthy individuals are entering the market and whether Blue Cross knew the reason. **Mr. Hutchins** answered that it is the nature of individual health insurance that people that enter the market are healthier than the people leaving it. This would have taken place regardless of the expansion. **Mr. Varin** agreed and added that Regence has been able to offer more competitive rates due to the expansion. Having a higher rate for the less healthy and having the high risk pool available has allowed the risk to be spread across a greater number of people. He could not say that the increase in enrollment was necessarily the result of younger, healthier people enrolling.

Senator Stegner said that he would like to eliminate the rate bands altogether and see what happens. It is a fundamental philosophy of government to let companies compete for business without government involvement. In his opinion, this would help unhealthy people afford coverage. On the other hand, he would like to look at the additional data and would be willing to extend the deadline for rate band elimination in order to see that information.

Mr. Tony Poinelli, Idaho Association of Counties, informed the Task Force that the counties are experiencing cost increases similar to what has been discussed today. This past year, a survey of counties showed that counties are spending $16 to $17 million dollars in medical care for indigents. The catastrophic fund is at approximately $13 million. This has gradually increased over the last few years. The larger areas, such as Ada and Kootenai Counties, are experiencing more dramatic increases. Counties are able to seek reimbursement for the catastrophic fund from individuals, although not everyone pays.

Mr. Poinelli stated that for the last few years, counties have been receiving many more claims for mental health cases. Another issue that is being explored is whether the money the counties are spending for the catastrophic fund can be used to match federal money. They are looking at developing a program that can mirror Medicaid but can be kept at a county level as an incident-based program. This is in the early stages of development. **Mr. Poinelli** also commented that in 1996, the recodification of the indigent law made the program easier to understand and most counties do follow it.

Representative Henbest asked if any other states have been granted waivers to do an incident-based program. **Mr. Poinelli** said that he is not sure if other states have been granted specific waivers. In most cases, counties are not as involved as they are in Idaho. The counties feel very strongly that part of the program needs to remain incident-based while the lien and reimbursement ability need to stay in place.

Mr. Millard commented that the IHA has worked closely with the counties for many years because most payments go to hospitals. He also mentioned that the hospitals have a good

working arrangement with the counties. When things are not working for either side, they will work it out at the boardroom table rather than in the courtroom.

Senator Cameron distributed Regence BlueShield's pamphlet that lists the rates and benefit structure for the high risk pool. He mentioned that the rates are set by the high risk board so they are the same for both carriers. Any differences would be in the benefit structure.

The next meeting was scheduled for September 11, 2003 at 9:00 in the Senate Majority Caucus Room. The meeting was adjourned at 3:15 p.