Committee Minutes:

Health Care Task Force

Senate Majority Caucus Room

State Capitol, Boise, Idaho

Wednesday, October 8, 2003

9:00 a.m.

MINUTES

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

Others present included: Bob Seehusen, Idaho Medical Association; Julie Taylor, Blue Cross; Jack Jones, AARP/Council on Aging and AAA; Joe Gallagos, AARP; Norm Varin and Lyn Darrington, Regence BlueShield of Idaho; Vic Moretto, St. Luke's Regional Medical Center; Bonnie Haines and Steve Millard, Idaho Hospital Association; Ken McClure, Givens Pursley; John Summerton, Strategic Employer Benefits; Woody Richards, Moffatt Thomas; Steve Tobiason, Idaho Association of Health Plans; Chris Pickford Ph.D., Employers Health Coalition of Idaho; Andrea Him, Sullivan and Reberger; Kelly Buckland, State Independent Living Council (SILC); Michelle Gardner, M.D., Idaho Academy of Family Physicians (IAFP), Idaho Nurses Association (INA); Neva Santos, Idaho Academy of Family Physicians (IAFP); Kate Vanden Broek, Idaho State Planning Grant; Brent Nye and Jim Stark, Boise School District; Teresa Molitor, Idaho Academy of Commerce & Industry (IACI); Shad Priest, Department of Insurance; Kathy Balmer, M.D.; Ed Lodge, Connolly & Smyser; Cindy Anderson and Rich Hahn, Idaho Power; Heidi Kilian, DirecTV; Melanie Decker, DirecTV/Employers' Health Coalition of Idaho (EHCI); Flinda Terteling, Terteling/Western States/EHCI; Jason Kreizenbeck, Micron; Colleen Brenton, Micron; Carol Brassey and Vicki Schab, Idaho Department of Labor; Elizabeth Criner, IPCA; Charles Novak, M.D.; Benjamin Prinzing & Susan Bryan, students; and Sue Reents.

A panel was invited to discuss mental health services in the state. **Mr. Bob Seehusen**, Idaho Medical Association (IMA), was the first speaker. He stated that the IMA represents 80% of the physicians in the state. He noted that the lack of mental health services in our state also affects the other 20% of physicians in their daily practices. **Mr. Seehusen** stated that mental health care services are the weakest link in the health care delivery system in Idaho. Another issue connected to mental health is people with dual-diagnosis of both mental illness and substance abuse. Access to treatment for mental illness is a real problem and, in some areas, there is no access. People with money can usually find services; people of modest or no means or without insurance have a very difficult time and this usually results in some deterioration to the point where they eventually show up in emergency rooms and need considerable care. Patients are then released after being given medication. Once they stop the medication or cannot afford continued medication, they are back in the system again. In many rural parts of Idaho, there are no mental health services or professionals and no inpatient secure beds designated specifically for mental health patients. The hospitals are not equipped to treat people who are a danger to themselves and society. The police must transport them elsewhere or they are medicated, put into the police car and later released. In rural areas in some states, a county medicates a patient, buys them a bus ticket and sends them to a larger city.

Mr. Seehusen continued by stating that counties face an ongoing struggle to pay for mental health treatment. The state regional offices are in place, but they are funded at a level where they have to screen out more people than they can take in. The location of state hospitals is often debated and is a sensitive issue. Idaho has two state hospitals, both of which are far from major metropolitan areas, meaning transport is costly. There are a limited number of certified beds in those state hospitals. Over the years, certified beds have decreased and many struggle to get Medicaid reimbursement for some of those beds due to resources available to the hospital. There is a shortage of psychiatrists as well as nurses and support staff.

Mr. Seehusen noted that the panel today included three physicians who are truly experts: Dr. Charles Novak, who is a psychiatrist in Boise who works with the mentally ill and advocacy groups; Dr. Michele Gardner from Grangeville, who is a rural physician and represents the family physician's perspective; and Dr. Mike Mercy who works in St. Luke's emergency room in Boise and can share the struggles and challenges faced in a larger metropolitan area with limited resources. **Mr. Seehusen** asked that the Task Force take the testimony presented very seriously in hopes that in working together plans can be formulated to deal with this mental health issue. He added that the panel simply came to share the urgency of mental health problems in Idaho and to ask for help from the legislative leadership**.**

Mr. Steve Millard, Idaho Hospital Association (IHA), next addressed the Task Force. He stated that the IHA is passionate about this mental health issue and emphasized it is a huge issue for our state. He noted that the Governor's Blue Ribbon Committee recently published an article on mental health, and the IHA has put together a task force on mental health to look at the issue from a hospital perspective. The membership of the task force includes: Vern Garrett, CEO of Intermountain Hospital and a very strong advocate of mental health; Pete Snider, Behavioral

Health Director of Eastern Idaho Regional Medical Center; Sue Curick, Syringa General Hospital in Grangeville; Kathy Connerly, St. Joseph Regional Medical Center in Lewiston; Kathy Balmer, St. Alphonsus in Boise; Carmen Broshew, Chief Nursing Officer in Kootenai Medical Center in Coeur d'Alene; Bill Southwick, Behavioral Health Center for Magic Valley Regional Medical Center in Twin Falls; Rod Jacobsen, Administrator of Bear Lake Memorial Hospital in Montpelier; Greg Mauer, CEO of Elmore Medical Center in Mountain Home; Bill Ringer, who sits on the Board of the Elmore Medical Center and who has said that the only mental health service in Elmore County is the police; Mark Adams, CEO of West Valley Medical Center in Caldwell; Ray Liable from State Hospital South; and Jay Kissinger from State Hospital North. The following issues were identified by the task force:

1. Capacity
2. Involuntary holds
3. Lack of protocols
4. Immediacy of treatment not available
5. Screening by entry-level law enforcement
6. EMTALA (Emergency Medical Treatment and Active Labor Act) requires that a hospital screen every patient. The definition of that screen is inadequate where mental health patients are concerned. **Mr. Millard** cited an incident where a mental health patient who was admitted into a surgery unit in ICU obtained heart paddles and shocked himself to death, underscoring the serious safety issues at stake.
7. Reimbursement from small counties
8. Fragmented care
9. Scope of health insurance coverage
10. Drug abuse versus mental health coding; how do hospitals get paid for these services?
11. Discharge and involuntary commitments

The most serious issues identified by the task force were:

1. Possible recodification of the involuntary commitment statute.

2. Review the sections of Idaho Code dealing with volunteer patients. This may involve restructuring the community mental health system. This is a monumental task, and will require assistance from everyone in the state.

Mr. Millard expressed the need for action from legislative leadership and offered the resources of the IHA in such an endeavor.

Representative Bill Deal asked if it was too early to gain insight into the topic of restructuring of the community mental health care system and what elements would be involved. **Mr. Millard** responded that the other speakers could better address that, but he stated that the counties and the IHA, along with the Department of Health & Welfare, have been working on this issue for over five years.

Dr. Michelle Gardner, Grangeville, Idaho, was the next speaker. Dr. Gardner practices medicine in a community of about 3,000 people and services a county of about 15,000 people. She trained in Houston, Texas, and was trained for rural medicine. She has been in Idaho since 1995. She expressed hope that the problems associated with the lack of mental health services in Idaho are now coming to the attention of leadership.

Dr. Gardner stated that she represents rural physicians in Idaho, who rate the quality of mental health for their patients about the same as general health, which is good or fair. Ninety percent of the rural physicians agree that they have problems getting mental health care for their patients. Eighty-six percent of rural physicians think the problem is due to a lack of psychiatrists. Eighty-two percent said their patients cannot afford mental health services and, even though they may have insurance, their insurance may not cover mental health services. If insurance does cover such services, it is often at a much reduced rate or they have large deductibles. Those are the top reasons why patients of rural physicians do not get mental health services they need. In rural communities, ninety-eight percent of mental health care is provided by rural family physicians. These doctors specialize in family practice and are not experts in mental health issues. Dr. Gardner's community in Grangeville has a 17-bed hospital where there is no ICU, no specialists, surgeons or emergency room physicians, and she provides on-call support to the hospital with other family practice physicians. Her hospital sees about 60 patients per year with psychiatric crises. She could be in the middle of delivering a baby or setting a broken bone and gets a call for a mental health crisis. Grangeville is 71 miles from the nearest facility with psychiatric services.

Dr. Gardner noted that in her home state of Texas, a patient can be held for 72 hours against their will while commitment is in process to protect that patient and society; we do not have that luxury in Idaho. Local law enforcement cannot hold these patients in local county jails because that is also against the law in Idaho. Physicians are therefore forced to hold these mental patients in their facility to keep them safe, but they are not safe and neither is anyone else. She gave an example of a gentleman in his 30's who was brought into her hospital after a domestic violence dispute, face down on a stretcher with three law enforcement officers on top of him, strapped, handcuffed, taped to the bed with bindings around his wrists to keep him from bleeding to death. The man was screaming profanities pleading to die. Dr. Gardner's job was to figure out what had happened, fix the problem and stabilize him. The man had taken an aerosol can in his jail cell, bent it in half and slit his wrists. He wanted to die; her job was to stop the bleeding and take care of his mental illness. A local mental health service provider happened to be in the hospital deemed that this patient was not suicidal and allowed the man to stay at the hospital facility. Dr. Gardner did manage to get this patient transferred to the state hospital in Orofino. This is just one

of sixty incidents per year that occur in one small Idaho community. Dr. Gardner has also had a judge court-order admittance to her hospital for a mentally ill young woman who was "hearing voices that were telling her to kill herself, blow up the hospital and hurt someone else." The law enforcement did not come to assist. The patient spent 48 hours in the hospital getting her vitals checked and being fed, but no mental care could be provided. Rural physicians face frustration and helplessness over such situations; these are real life situations here in Idaho that occur on a daily basis.

Dr. Gardner said she sees the need for a complete restructuring of the mental health system in Idaho. When she was in training in Texas, she was required to pass a jurisprudence test. Part of that test required a physician to know the mental health laws of the state. She struggles with that in Idaho, as she does not think it works well and few understand it. It may require changing laws to assist physicians. She noted that the average stay for a patient is two to three days in a facility; the patient is then released back into the general public and there is little follow up. Consulting psychiatrists burn out quickly due to overload; more psychiatrists need to be recruited to the state to relieve the burden of the few Idaho has. Idaho needs more regionalized care, either more facilities or better access, but access must be around the clock.

Senator Joe Stegner requested Dr. Gardner's opinion on an estimate that between 60-80% of mental health patients in the state have a diagnosed substance abuse problem, and asked how well she thinks the state handles substance abuse issues. **Dr. Gardner** responded that most mental health patients in rural communities carry a mental illness diagnosis, and most often they have an added diagnosis of substance abuse, which may be alcohol or drug-related. She agrees the statistic is very high and that the two are related. They had one AA meeting per week available in Grangeville at one time and there used to be a Port of Hope Clinic in the community, but due to lack of funding it was closed. Some private counselors have now set up AA meetings six days per week, which is an improvement, but often the problem is more complex. When a depressed, suicidal patient needs treatment in a psychiatric facility, there may be the added, dual diagnosis of alcohol or substance abuse and facilities will not deal with both issues. They will treat only the mental diagnosis. Substance abuse is very prevalent, especially in rural areas in the state. She agrees with the statistic and it adds more difficulty to getting mental health patients into treatment facilities.

Representative Kathie Garrett stated that Medicaid is looking at possible reimbursement for teleconferencing psychiatrists and asked if that would help in rural communities. **Dr. Gardner** responded that physician teleconferencing is a benefit in rural communities when a specialist is needed. As an out-patient mechanism for people with mental problems who may be stable, it could be very helpful; in a crisis, it is not helpful.

Senator John Goedde asked if there is an inventory of assets state-wide regarding hospitals for mental health beds and substance abuse. **Mr. Millard** responded that there has not been an inventory taken, but that it would be easy to get that information and volunteered to do that for

the Task Force. **Senator Cameron** stated that it would be helpful to have a proper understanding of how the system is supposed to work in Idaho after hearing testimony of how it is *not* working. In future meetings, the Task Force needs to hear from Medicaid and the mental health hospitals in the state. The Task Force also needs to look at current expenditures and examine whether the state is putting funding into the proper areas and how adjustments can be made.

Charles Novak, M.D., spoke next. **Dr. Novak** stated that he is a psychiatrist who has lived in Idaho for 18 years. He has worked mostly in hospital psychiatry, and works at St. Alphonsus and Intermountain Hospital and was past President of the Idaho Psychiatric Association. He is familiar with issues around the state. For eight years he sat on and was chairman of the new panel for federal block grants given to the states for mental health. In looking at an overview of what has happened to mental health since coming to Idaho, he asked the Task Force to keep in mind that figures often show that Idaho is between 47th and 50th in the states in the per capita amount of money spent on people for mental health treatment; he emphasized that this figure includes only state money that goes toward treatment of people usually in the context of block grants, which means non-hospital based monies that are spent for non-hospital care. Federal block grant money is seed money sent to states to increase their levels of care. Idaho spends a small amount of money per capita, but Idaho spends all kinds of money on mental health in this state, especially when money spent in the jails is considered. The ratio of people with mental illness in Idaho's prison system is higher than most states by far, depending on how mental illness is defined. Idaho spends a great deal on jails, prisons, county systems, police and civil commitments. Access to state hospitals currently is only by voluntary commitment unless a person is civilly committed, which costs money. Idaho spends a lot of money on mental-related issues in the emergency rooms. There are many people who end up with medical complications from their mental illness when admitted for an overdose or for cutting their wrists, so when looking at finances, these issues have to be considered. Therefore, looking at how much money is spent needs proper explanation. There may be small sums of money spent for medicines when, in reality, the state is spending more money in other areas that need to be considered.

Dr. Novak stated that access is the key issue. His night-time calls have gone from one to two per night to calls every hour or two hours. He stated that this can be expected in the Boise metropolitan area, but the calls are coming from other parts of Idaho looking for beds. Hospital access is important, but what needs to be reviewed is the access to outpatient care and treatment, which includes both mental health and substance abuse treatment. Access to mental health care has gotten much worse and there are certain parts of the state where people without Medicaid, Medicare or insurance can get some access to some medicines, but in most of the state that is nonexistent. Many of those people end up in emergency rooms, in mental hospitals, jails or prison. The community mental health center system is varied in the state and does have different areas to have different target populations. It is still hard to find doctors who accept Medicaid; Medicare has become difficult also particularly with people with serious mental illnesses who don't have Medicaid and have no access to medicine.

Dr. Novak emphasized the issue of insurance; people in Idaho with basic insurance have substantial limits, so if a family member has a young schizophrenic there may be a $5,000-$10,000 limit and relatively large co-pays (usually 50% for out-patient treatment) with the same limits. So, the reality is that as much as insurance does help in certain situations and populations, persistently mentally ill patients use up their benefit almost immediately and then are off the insurance option. There is a constant flow of severe and persistently mentally ill people who are insured and move to the uninsured status in a short period of time.

Representative Garrett asked if Dr. Novak could address Medicaid reimbursement rates and teleconferencing. **Dr. Novak** responded that teleconferencing has been used in other states relatively successfully; it must be used, in his opinion, in the context of training. Nurse practitioners, medically trained personnel and family doctors can use psychiatrists to learn via teleconferencing. A backup for access to medicines in crisis care is also necessary. Without all those elements, problems and possible lawsuits could result. Medicaid reimbursements to psychiatrists were to have come up to the level of Medicare reimbursements, which are also problematic to some degree. This may help some clinics, but in reality almost no doctors will treat many Medicaid patients. Most doctors set some limit because they cannot run a practice that makes money on Medicaid. Most places that accept Medicaid and have access are hospital-based clinics, so Medicaid certainly has not attracted specialists, in his opinion.

Representative Garrett inquired about ACT teams and how many there are in the state. **Dr. Novak** answered that ACT teams are theoretically available in all regions of the state; the problem with ACT teams in Idaho is that they are variable. That is a plus and a minus. ACT teams have been established with different roles around the state; we don't have, in his opinion, any true ACT teams in Idaho. True ACT teams are set up with an array of services that include vocational rehabilitation, substance abuse treatment, and a well-rounded set of services. The ACT teams in Boise try to keep patients who have done dangerous things on medicines so they have less risk to the population in general and can stay out of hospitals, prisons and jails; and that is all they do. They essentially chase a group of people around trying to ensure they stay on their medicines and out of trouble. Other ACT teams do similar things but many times the ACT teams are more case-management teams that do the same thing with a different population. In general, ACT teams are good; Idaho's ACT teams, however, are not as sophisticated as those in other states.

Representative Garrett mentioned that Idaho Falls has a mental health court similar to the drug court and asked how that was working. **Dr. Novak** does not have an opinion as to how that is working. Some states believe the mental health courts are a more efficient way of handling things and it does make some sense philosophically.

Representative Deal referred to parity in insurance coverage provided by private insurance companies such as BlueShield and Blue Cross. Some legislation has been brought forth in past years having to do with mandating some better, more broad coverage instead of limited amounts

of coverage. In private health insurance programs, if there were broader coverage for mental health, would there be some offset from costs that the mental health disease creates in the broader physical needs of a person that are already being paid for in health care, and could health care costs be saved if medication could be provided for these mentally ill patients?

Dr. Novak responded that the reality is that even though statistics argue the "black hole" argument, the lines for mental health treatment can certainly show a number of states that have had parity, relative parity and not substantial parity and insurance companies have not increased rates and premiums the reality is that most of the data has stayed consistent over the years relating to cost offset idea and the fact that severe, persistently mentally ill people (particularly those with depression) have many other medical costs. If the depression or mental illness is treated appropriately and aggressively, a lot of money can be saved -- the estimates are 10-20% generally in offset medical costs. People who do not get depression under control have anxiety and, subsequently, other medical problems which mean expensive treatment and services. There is no doubt that medications to treat mental illness and depression can alleviate other huge costs for assessment, hospital services and emergency rooms.

In response to a question from **Senator Stegner**, **Dr. Novak** stated that ACT team stands for "Assertive Community Treatment" team. **Senator Stegner** expressed hope that the Task Force fully appreciates the intention of ACT teams for populations in regions where the persistently mentally ill wind up in the system, are treated in some manner, returned to society and later re-enter the system on a fairly consistent basis. ACT teams identify these people and are actively involved in trying to keep these people out of the system with more productive lives. He thinks ACT teams are fairly successful on a national basis and evidence in Idaho shows that the percentage of people returning and cycling through the system has been significantly reduced, with some limitations. He asked if the ACT team concept was an area worth funding, by designing a system that will increase ACT team availability in the state. **Dr. Novak** responded that he believes that ACT team philosophy has been very effective in some states that utilize their services adding a quality of life with dignity for many people who had a fairly undignified existence for a long time. As far as case management types of options, **Dr. Novak** believes that it will help people and also reduce costs.

Senator Fred Kennedy asked how many practicing psychiatrists work in Idaho and where they reside. **Dr. Novak** responded that most are members of the IMA and on that list there are around 100. Half of those reside in southwest Idaho; the Boise area has up to 30, northern Idaho and southeast Idaho have similar populations. The state hospital in Blackfoot has had from five to ten psychiatrists intermittently over the last few years; Northern Idaho has one or two covering that hospital, due to a smaller number of beds. Many have moved out of the state. **Senator Kennedy** asked for recommendations as to how the legislature could assist the state in recruiting psychiatrists to Idaho. **Dr. Novak** said that Idaho has much to offer. The issue with psychiatrists, in his observation, is that they require a quality of life, and part of the problem with those who come and leave is related to becoming overwhelmed with practices that end up with too much Medicaid and fewer doctors who accept Medicaid. There is a stigma attached to taking care of

people who are persistently and severely mentally ill, and a doctor is at risk in one way or another, so many doctors prefer to work in clinics or hospitals where there is some level of protection and less hassle. Doctors in rural areas must be on call at all hours; many specialists are not willing to do that without backup. A psychiatrist in Grangeville would be handling those 60 patients per year that Dr. Gardner referred to with no backup system. How do you allow a doctor to enjoy the things in Idaho they came to enjoy with their families without making them feel they are overwhelmed and under-appreciated?

Senator Kennedy inquired whether a reasonably subsidized mental health clinic could better serve rural areas of the state. **Dr. Novak** responded that such clinics may be the key to restructuring Idaho's community mental health system. Even small, rural communities could set up a system in which they have a psychiatrist or psychiatric practitioner who does not have to be on call around the clock who could have an ACT team or others trained well enough to serve that community who could have a good working relationship with a hospital or crisis facility in their area. They could then make outpatient treatments, with crisis treatment available. Prioritizing such treatment means less stress on emergency rooms and hospitals. This would be more cost effective, especially when considering what is spent in the legal system where mentally ill persons are using up lots of money inefficiently. The states that have successfully done this have done it in different ways. Some have given money to counties, while others have provided money to cities or to regional mental health centers that used to be state mental health centers. **Dr. Novak** emphasized that Idaho has separated mental health and substance abuse from a bureaucratic and financial standpoint; there is some subsidized substance abuse care. It can be as simple or complex as a state wants to make it, but a state must find a way to prioritize people who know how to successfully treat substance abuse problems. The state needs to provide incentives to people who try to do that work, and if they do it well, to be reasonably reimbursed. In some states they do this as part of the mental health system and it is probably the best way to do it.

Representative Garrett commented that she had met with Ray Millar of adult mental health, Department of Health & Welfare, to find out what direction they are going. According to Mr. Millar, the Department is in the process of putting together "best practices" and a broad base of people are getting involved. The Department wants speciality ACT teams consistently available in all regions in the state. Representative Garrett encouraged involvement in those ACT teams.

Senator Cameron asked for clarification on mental health parity. He stated that this may be a simplistic answer to a more systemic problem in how the state treats mental health patients and how Idahoans who have mental health problems can access treatment. If this Task Force were to approach the mental health services problem, it needs to work more on the systemic treatment first as a priority approach by boiling down the information received. **Dr. Novak** answered that terms such as "make access easy" and "open door policies" make people uneasy because there is a stigma attached, a black-hole perception, and concern that mental health will get out of control and cost too much money. However, the reality is that currently there are many levels of access to care that are inefficient, particularly in the legal and jail systems, so the bottom line is that if

the state can restructure the system so that every region has access to outpatient or crisis intervention care and some bed availability, patients can be treated in a more dignified manner with far fewer problems in emergency-related issues and social problems with less substance abuse. Financial savings will result with better mental health care. Idaho is small enough that it would be very easy to accomplish. Access to *appropriate* care is a better solution rather than access to *any* care.

Senator John Goedde addressed financial incentives. He stated that mental health issues don't necessarily ever stop, and asked how to provide financial incentives to treat mental illness. **Dr. Novak** pointed out that if the worst prognosis in psychiatry (schizophrenia) is compared to a seizure disorder or diabetes, doctors can diagnose all of these illnesses with reliability, the treatments are set, and the treatment works about two-thirds of the time in heart angioplasty as well as for schizophrenia. With follow up and medication, treatment is available, treatment works and treatments are definable. The notion that there is a "black hole" comes from the notion of psychological treatments and even doctors will explain that there is a defined treatment regimen for certain illnesses, but we all know that even indefinite psychotherapy can revamp a personality to improve quality of life. If people are paid to see a "shrink" or a psychotherapy benefit is offered at an 80% reimbursement level, people will go see psychotherapists. People generally do not over-utilize therapy; more often they need encouragement to continue taking medications.

Dr. Mike Mercy, Medical Director of the St. Alphonsus emergency department, spoke next. **Dr. Mercy** is also on the staff of Elmore Medical Center in Mountain Home and at St. Luke's in Wood River, Ketchum. In Boise, there are accessible services; in Ketchum, there are people with significant personal resources and very few portals of access for mental health care. The bleakest mental health care environment is the small, rural community. Elmore Medical Center has 17 beds in the facility and the arbiter of mental health care is a 19-year old sheriff or a city officer who has had little or no mental health training. This person determines a person's access to the system for health care. Many hospitals and medical centers refuse to admit a patient to a general medical floor who lists mental health care as a primary reason for admission. The reason is simple -- it is not appropriate for a person who could hurt themselves or others to be admitted into an unsafe environment. This creates problems for the practice in emergency medicine.

Dr. Mercy stated that he is in contact with other emergency physicians in the state, who claim that mental health care is the single issue that gives physicians more trepidation as a presenting illness. In Idaho, the mental health services problem affects everyone, including many people who, if not for their mental illness, would probably be very productive members of society. A stigma that is attached to mental health illness is that there is something intrinsically wrong with that person. However, people who experience depression who end up in the emergency room have an illness as real as diabetes or coronary artery disease, and it is treatable. Unfortunately, our system does not allow that patient to get access to treatment which would bring them back to a level of functioning. The emergency departments in the state are the safety net for mental health patients coming in at unacceptable rates. These patients often need intensive therapy and

they access treatment at the most expensive place, the ER. The federal government mandates that an ER see everyone who comes to the ER door. This gets very expensive, and the ER is probably the least effective in delivering care to that patient.

Dr. Mercy said he believes that Idaho's communities need to be empowered by giving them resources to put into place experienced crisis care givers. He currently sees people who get so despondent that they attempt suicide and the emergency rooms are only able to give them temporary medicine and send them back into the community without an advocate and with no follow-up care. Currently, it is virtually impossible to get a patient in to see a psychiatrist without a three to four month wait, yet many of these people are suicidal. Substance abuse is as much an illness as diabetes or coronary artery disease, yet unfortunately the stigma is such that it also is difficult for leadership to go to constituents and plead for resources to help these people. A substance abuse problem may have led to an individual entering the legal system, but inherently they are not criminals. Substance abuse is rampant, but it is treatable if resources are made available. Unfortunately, there is a high percentage of mentally ill patients who also abuse or use substances. It may be their attempt to try to treat their problems. We cannot have a system that ignores substance abuse problems. We criminalize these people. Our jails are burgeoning and we build more; we need to be building more mental health care access.

Dr. Mercy continued by stating that there are not enough physicians; part of that has to do with reimbursement and the other part has to do with being on call around the clock in small communities. ACT teams can answer some of these dilemmas. While tele-medicine or teleconferencing is not good for a mental health crisis, a nurse practitioner could be trained to get the psychiatrist's expertise to help manage patients and keep them out of the hospitals. It is much more cost-effective to have regional psychiatric emergency rooms with a psychiatrist on call. Costs in a regular ER for a mental health patient are astronomical, about $700 for walking in if they are not admitted, mostly for routine tests that probably do not need to even be done. This money could be used to pay for a better system or medications. The police are the arbiter of defining mental illness and there are no resources to help train them; this is something that needs to be taken out of law enforcement. There are so many officers in the ER on a normal weekend dealing with mental health and substance abuse issues that it is phenomenal, and they should be out on the street. Our legal system, by default, has become our mental health care system.

Dr. Mercy said that prescription drugs can treat mental illness, but the patients need to stay on those medications. These people often do not have the resources to keep taking the drugs to keep them stable. There are cheap medications, but access is a huge issue. Best practice and best care must be established. These people must get the medications and stay on them. Such consistent medication will save the state money in the long run. Idaho's population is burgeoning, and more beds are needed. If it were profitable, someone would have built them; it is not profitable and requires financial support from governments.

Dr. Mercy stated that children with mental illness are "at risk" and could have their life affected significantly. There are 18 treatment beds in Idaho for children under twelve years of age; twelve are here in Boise and six are in Coeur d'Alene. Children have had to be flown via Life Flight to Coeur d'Alene in order to access services. Part of the treatment for mental illness is having a support network around you and close by to be successful. We need pediatric psychiatrists on call in our emergency rooms.

Dr. Kathy Balmer, Clinical Psychologist, Director of Behavioral Health Services at St. Alphonsus, spoke next. Dr. Balmer was formerly a senior vice president for an international psychiatric hospital corporation with hospitals in 44 states. She is a professional and technical advisor to the Joint Commission on Accreditation of Behavioral Health Systems (JCAHO) and also sits on several subcommittees on a national level, so brings both a national perspective and an Idaho perspective. As a hospital system that delivers both inpatient and outpatient treatment , access for the persons treated is a concern. Currently in Boise and the greater Treasure Valley area, there is an eight to twelve week wait for someone needing follow-up care in an outpatient setting. Medications for the average psychiatric patient cost a minimum of $500 per month, and most patients don't have coverage because they are uninsured or insurance does not cover those medications. Access to the medicines requires a prescription which requires access to a psychiatrist. There are 28 psychiatrists who practice in the Treasure Valley and only a small handful of those see patients who are uninsured or on Medicaid or Medicare. Waiting to get into the mental health system for Region IV for Health & Welfare can take a minimum of several weeks. Intermountain Hospital and St. Alphonsus both offer outpatient care and between the two hospitals, they provide 35,000 outpatient visits per year; at any given time they have about 2,000 patients enrolled in outpatient treatment.

Dr. Balmer stated that Idaho's public health system is broken. In the mid 1960's, the Public Health Services Act defined community mental health as a center that provided an array of comprehensive services for the mentally ill population. Those services included twenty-four hour emergency care, screening services for candidates for state facilities, psycho-social rehabilitation, day treatment services, ACT teams, outpatient services to geriatrics and to children, case management and medications. Some, but not all, of these services are available through various means around the state, but none are under one roof and none are coordinated. The difficulty in the private sector is that the patients who do fall into the system through the ER have sometimes been without medications for many months and none have the ability to access or understand the system. When we compare a mentally ill patient to one with diabetes, they are both conditions for life. If medication for one equals the insulin for the diabetic, then the community mental health wrap-around system is like the diet for the diabetic. If any part of that system falls apart for them, then the treatment does not have a successful outcome. **Dr. Balmer** hopes to pull these pieces together in our communities and reduce the inefficiencies. She believes a great deal of money is spent ineffectively and inefficiently. The current system provides services one on one, but one person could be serving ten people if services were coordinated under one roof.

Representative Garrett passed out a booklet entitled "The President's New Freedom Commission on Mental Health - Achieving the Promise: Transforming mental health care in America." It encourages dialogue and sets forth goals for the nation and Idaho. A copy of this publication is available in the Legislative Services Office.

Senator Cameron stated that he is beginning to get a clearer vision of the complexity of the mental health care problems in Idaho and invited written comments be submitted as well. **Senator Cameron** summarized that there needs to be a better understanding of the current system and the amount of money being spent. He referred to **Dr. Mercy's** study that reviewed how much Idaho is spending on substance abuse. The amount is in excess of $50 million per year through the Department of Corrections, the Department of Health and Welfare, law enforcement, etc. That figure does not take into account the money spent on mental health, but some will cross over.

Senator Cameron stated that what is really needed is an inventory of the services currently available and an understanding of how the current system works. The Task Force needs to hear from the Department of Health and Welfare, Medicaid and other interested participants to get a full understanding of the overall problem. One of the dilemmas is that there are many groups working on this issue and perhaps going in different directions. The Task Force needs to find a way to pull these groups closer together and then divide the problem into pieces and try to tackle one problem at a time. There is no quick fix and no easy solution. The Task Force needs to take an approach from a more global and statewide point of view. Perhaps what is needed is a better understanding of what other states are doing and which states have been successful. Currently, there is too much inefficiency and misdirection of appropriate care in Idaho for mental health.

Senator Stegner mentioned that he is unofficially involved with a group that has an interest in presenting some formulary legislation in 2004 and asked if this Task Force would be interested. **Senator Cameron** suggested hearing from the group in a future meeting. He said he anticipates further mental health presentations from Medicaid and the Legislative Services Office budget staff regarding current expenditures. There are other organizations who may want an opportunity to speak. **Senator Cameron** expressed an interest in hearing from the counties on several perspectives: Idaho is spending a great deal of money, the bulk of indigent and CAT funds going toward mental health or substance abuse, and perhaps those resources could be better spent particularly if matched through the current health and welfare system. In December the Task Force will hopefully be looking at various pieces of legislation, not just with mental health, but in other areas that this Task Force may choose to endorse.

Senator Stegner pointed out that the Association of Idaho Counties and a number of commissioners and employees from across the state have been working on mental health issues for over four years. There has been significant involvement with Health and Welfare. There is frustration in the group about trying to achieve overall change, and while the proposals they are introducing this year are modest, they are designed to foster and encourage the development of

community-based, regional mental health authorities that will be responsible for designing their own systems within a region and sharing assets. This group would like to present the legislation and the funding sources they have identified at the Task Force's November meeting. The legislation will be a proposal to encourage the development of full ACT teams across the state on a regional basis with the funding coming from the state. These teams will hopefully be the foundation for more coordinated regional efforts and recognition by the state that these regional community efforts are going to be more successful than management from top down.

Representative Deal addressed his concern that the Task Force has been dealing with the mental health issue on the periphery for a long time and with the help of the medical community and others, important changes can now be made in coordination of the resources.

Representative Deal moved to approve the July 29, 2003 minutes, as corrected, seconded by **Senator Stegner.** The motion carried by voice vote. **Representative Deal** moved to approve the August 19, 2003 minutes, seconded by **Representative Gary Collins**. The motion carried by voice vote.

Carol Brassey, Idaho Department of Labor, addressed the topic of the Health Coverage Tax Credit (HCTC). The Department of Labor administers the federal trade adjustment, which provides job search and training assistance to workers who have lost their jobs due to international trade and increased imports. With regard to implementing this program, **Ms. Brassey** gave a summary of what the Department of Labor and the Department of Insurance have done. The program, which became effective as of August, 2002, provides federal funding to pay 65% of an eligible individual's monthly health insurance premium for qualified health insurance through either a tax credit or advance payments. These otherwise eligible individuals have to be in a covered, qualified insurance program. A copy of a handout distributed by Ms. Brassey is available in the Legislative Services Office. **Ms. Brassey** noted that the Department is just now beginning to implement the program, and described the eligibility requirements for the 65% credit. Included in the eligible group are individuals who do not have other specified coverage such as a spousal plan where the employer pays 50% or more, Medicare Part A, Medicaid or SCHIP.

Ms. Brassey pointed out that the Department sends the number of TAA eligible people in Idaho to the federal data base on a daily basis. In September, 2003, the Department of Labor sent the names of over 19,000 people who were potentially eligible; family members of these individuals are eligible as well, but they cannot have other specified coverage. In addition to meeting eligibility requirements individuals must also be enrolled in qualified insurance. There are three types of insurance that are automatically qualified:

1. Automatic
    a. COBRA

   b. Spousal plan where employer pays less than 50%
   c. Individual coverage where individual was continuously enrolled 30 days before layoff
2. State Election
   a. State-based continuation;
   b. State high risk pool;
   c. State employee program;
   d. Program comparable to State employee program;
   e. Arrangements between state and (1) group health plan, (2) issuer of health insurance coverage, (3) an administrator; or (4) an employer;
   f. Private sector purchasing pool; and
   g. State-operated health plan that does not receive Federal financial participation.
3. Special rules for State-elected coverage mechanisms

   For "qualifying" individuals (i.e. eligible individuals with at least 3 months of creditable coverage, mechanisms must provide:

   a. Guaranteed enrollment
   b. No exclusion based on pre-existing conditions
   c. Nondiscriminatory premiums
   d. Same or substantially similar benefits

Because of these automatically insured insurance plans, this program is running in Idaho and a number of Idahoans are receiving the 65% premium assistance. There are many people who aren't enrolled in those three types of insurance. The issue that remains before the Department of Insurance and possibly the Task Force is whether the state should provide one of the possible options for state election. The best option appears to be the state high risk pool. Federal grants are available to the states to either develop a program or cut their losses from the programs, or to help make existing high risk pools conform to the requirements of this health credit tax program. Last April, **Ms. Brassey** made a presentation to the High Risk Reinsurance Pool Board, outlining the state elected options. This could be a marketing tool for insurance companies and rather than increase the underwriting risk, it would actually decrease the risk to get these people in the insurance pools. Most of the people laid off were people employed for long periods of time and were then laid off due to foreign competition or imports, so they were covered by insurance for years while they were employed. They are therefore considered good health risks.

Ms. Brassey continued by stating that the Board was hesitant to elect a state program because of the special rules for state-elected coverage mechanisms. In order to be qualified under the health coverage tax credit program, the state would have to guarantee enrollment, have non-discriminatory premiums, and have the same or substantially similar benefits. States are also prohibited from having any pre-existing condition clause for the subset of people who are otherwise eligible for the subsidy. Without state options, the only people who will get the 65% federal subsidy in their health insurance costs are the people who have automatically qualified insurance. The Board expressed that it did not think it was feasible to have a state high risk plan

that did not include a pre-existing condition clause.

Ms. Brassey emphasized that the Department of Labor's role is limited to sending names of eligible TAA individuals to the federal government. It is the federal government's responsibility to find out what kind of insurance these individuals have and whether it is qualified. The Department is receiving no feedback, so she doesn't have information regarding how many Idaho citizens are actually getting the 65% federal subsidy. She noted that there are many Idaho companies that are listed as eligible under the TAA program, including Micron, Zilog, JR Simplot, Jabil, and many other companies who have been trade-certified.

Senator Cameron mentioned that he and Representative Deal serve on the High Risk Reinsurance Pool Board together and he invited discussion about the role of that Board regarding a state-elected coverage option. He noted that the Board was not in a policy-making position to make that determination. **Senator Cameron** asked whether the only change that the pool would have to make in order to qualify is the requirement that there be no pre-existing condition clause. **Ms. Brassey** answered that, according to Joan Krosch of the Department of Insurance, that is the only obstacle. She noted that only the special group of qualifying individuals must be offered the plan without a pre-existing condition clause. **Senator Cameron** reiterated that Idaho could still maintain pre-existing conditions on non-qualified individuals who would choose to be part of the high risk pool either because of health conditions or other reasons, and the pool would only have to allow for an exception for these qualified individuals. **Senator Cameron** asked if other states had modified their high risk pool plan to create a separate new plan for these qualified individuals. **Ms. Brassey** responded that she did not know, but that most states did have to pass legislation in order to make the changes they needed.

Representative Max Black asked whether there is an ongoing funding source that Idaho could access. **Ms**. **Brassey** responded she did not think so, and that Congress had passed appropriations for two different types of grants. There was a limit per state of $1,000,000 to create a high risk pool, but a state could get funds to modify an existing high risk pool so that it would quality under this act. There was also money to help states cover the cost of losses to their high risk pools. There were appropriations of $20,000,000 to help develop and $80,000,000 to help offset losses, but she was not aware of any further appropriations. The deadline for applying is March of 2004. The benefits will be to the citizens who are able to get coverage under one of these state-elected options because they would then have 65% of their health insurance premiums paid for two years. The time limit for each individual is two years or until their TAA certification expires, whichever occurs first.

Representative Black asked whether Idaho allows self insured participation in Idaho's high risk pool or whether they transfer in? **Senator Cameron** explained that any individual who no longer is eligible for coverage under their employer's plan would then be eligible for the high risk pool, so the question is whether or not Idaho wants the federal government's subsidy of that premium. If an individual exhausts their COBRA and comes to the high risk pool, the premium is $300 per

month. Under the current system, the individual pays $300 per month; under the proposal, the federal government would pay 65% of that cost.

Senator Goedde stated that the state has identified over 19,000 individuals as potentially eligible; there is a certain number of potentially eligible individuals who will be qualified under this definition, and some of those will be automatic, and then the other portion of those qualified individuals, if Idaho elects to make the high risk pool comply, would be eligible for enrollment in the high risk pool. **Ms. Brassey** affirmed that was correct. **Senator Goedde** asked what that number was and who was going to make that determination. **Ms. Brassey** stated that the Department of Labor has no way of knowing, but that all of the 19,000 are basically eligible, and if they have insurance that is qualified, they will get the subsidy. It is unknown how many of those individuals have insurance or meet that special definition of "qualified." The state does not have an obligation under this law to counsel these people on insurance or in any way help to determine whether the insurance they have would be qualified.

Senator Goedde stated that given the scenario of the $300 premium, an individual who is enrolled in the high risk pool, if eligible, would receive a two-year tax credit and this would probably make the high risk pool premium more attractive than an individual product outside the high risk pool. If it is assumed that people who are qualified are probably healthier than those people generally in the high risk pool, the high risk pool wins as well because they are getting $300 per month from an individual that actuarially would not expend that. The offset is that the pre-existing clause would only apply to those individuals who would qualify with this program. If that's the case, it sounds very attractive.

In response to a question from **Senator Stegner**, **Vicky Schab**, Department of Labor, explained that the only time people are eligible for the tax credit is if they are collecting unemployment insurance. The two years refers to only the time in a month during which they get an unemployment insurance check. The first requirement is that they must have worked for a trade-qualified employer and they must have applied for coverage under the trade act and been issued paperwork that says they are eligible; then they must get an unemployment check or, if they run out of regular unemployment, get an extension called a trade readjustment allowance.

Senator Stegner reiterated that since the state does not know how many of the 19,000 individuals are qualified, it could be that every one is qualified and could be getting the tax credit. The fact is that today there are some employees in the state who are getting the tax credit; we just don't know how many. In response to a question from **Senator Stegner** relating to agricultural businesses, **Ms. Schab** stated that any company can file a trade act petition by contacting the Job Service office. When a petition comes in, an investigation is conducted by the national office and certification is issued. If the company meets certain criteria, and the national office certifies it as trade-eligible, then former employees of that company can receive the credit. **Ms. Schab** stated that the criteria for certification includes: significant layoffs, reduction in

production in the product produced and import data that shows that the product produced has experienced an increase in imports during that time period.

Senator Goedde stated that maximum unemployment is 26 weeks. That is offset if an individual earns money, so it could be longer than 26 weeks. If one week per month a person earns enough that he does not get an unemployment check that week, what does that do to a person's eligibility for this program? **Ms. Brassey** answered that an individual is eligible if he or she receives one unemployment check during a month.

Senator Cameron explained the current eligibility requirements for Idaho's high risk pool: (1) based on a health condition and (2) the health insurance premium available to the individual is higher than that offered by the pool. He noted that for the pool to qualify under the Trade Assistance Act, there would have to be a third eligibility qualification to include TAA eligible individuals. Such an exception would also have to provide that no preexisting condition clause would apply to these individuals. **Senator Cameron** clarified that the reason for having a preexisting condition clause in the high risk pool was to avoid providing an incentive for individuals who did not have coverage but then find out they have cancer and then come to the high risk pool to purchase coverage. That situation may not occur with individuals who are displaced workers who are wanting to maintain coverage. The Department of Insurance is receiving numerous calls and requests from individuals who are wondering why Idaho has not opted in under the TAA program. **Senator Cameron** noted that the Board was led to believe the pool would have to eliminate preexisting conditions for the entire pool. Given that this is not the case, the issue of creating an eligibility "carve out" for TAA eligible individuals is an option the Board should review.

Shad Priest, Department of Insurance, confirmed that the Department has received numerous complaints. Consumers are aware that the federal credit is available, and wonder why Idaho is not allowing them to take advantage of it. He added that a segment of the high risk pool could address the qualified applicants. One of the problems is that the statute needs to be changed to ensure that people can get into the high risk pool plan regardless of their eligibility for a street product.

In response to a question from **Representative Black**, **Ms. Brassey** stated that the federal government had assured her department that the health care tax credit is a permanent program. She noted that Idaho has a number of industries that are affected by foreign imports and trade agreements. The impetus for the federal act was a combination of a desire to work with companies affected by foreign imports and federal trade legislation and a concern about health care coverage for individuals who have lost their jobs due to the bad economy.

Senator Goedde suggested that the Department of Insurance and the High Risk Pool Board proceed with preparations in providing an exemption in the high risk pool for purposes of the

Trade Assistance Act. **Senator Cameron** commented that the Board may want obtain an actuarial assessment as to the cost of a carve-out plan.

Senator Goedde moved that the Task Force instruct the Department of Insurance and the High Risk Pool Board to proceed with preparations for a potential expansion for the tax credit, seconded by **Representative Deal**. The motion carried by voice vote.

Dr. Chris Pickford, representing the Employer's Health Coalition of Idaho (EHCI) as current chair and member from the Boise School District, was the next speaker. She introduced other members of the EHCI in attendance as follows: Jim Stark from the Boise School District, Colleen Brenton from Micron; Heidi Kilian of DIRECTV; Cindy Anderson, past chair of the EHCI, from Idaho Power. The EHCI is comprised of representatives of large employers in Idaho who meet monthly focus on health care concerns. A pamphlet regarding the EHCI was distributed. A copy is on file in the Legislative Services Office.

Dr. Pickford explained that the EHCI began in 1981 in response to increasing health costs. Costs have risen 400% since then. The EHCI provided more than $345 million in employer-sponsored health care coverage to 154,000 employees, retirees and their eligible family members in 2002. Health benefits are a key part of recruitment and retention for employees. EHCI member companies encourage dialogue on health care issues among employers, insurers, employees, members of the health care community, lawmakers and the general public. The corporations in the EHCI communicate to inform senior level management about costs, and this year the EHCI has begun to talk with legislators due to the rate of increase which is reaching significant proportions and is of great concern to companies.

Dr. Pickford shared a handout entitled "EHCI - Employers' Health Coalition of Idaho" (a copy is available in Legislative Services) which sets forth an overhead presentation that shows health care cost increases. The rate of increase just since 2000 is approximately 8%; for 2003, if no plan changes were made, premiums would increase over 20%**.** Employers, along with local and state governments and the federal governments, are the dominant purchasers of health care, and a large employer, such as the state, is not buffered from the effects of the increases based on advantages of pooling. The companies speaking before the Task Force are present because they and other businesses are beginning to act like businesses in healthcare purchasing.

Cindy Anderson, Vice Chair of the EHCI, presented aggregate data from ten company members of the twenty-three member EHCI. The data is credible due to the large numbers of people the data represents and is representative of the ECHI membership as a whole.

In response to a question from **Senator Cameron**, **Ms. Anderson** stated that probably more than half of the companies reflected in the data are self-insured. She estimated that more than 75% of the EHCI companies are self-insured. **Ms. Anderson** pointed out that the EHCI found that between 1998 and 2002, annual employer costs per covered life rose an average of 52%: from

$2,066 in 1998 to $3,140 in 2002. By category, during the same period, the costs increases were as follows: health care - professional (doctor and surgical needs) was up 42%; health care - facility (hospitals both in and out-patient) increased 33%; x-ray/lab costs went up 66%; and prescriptions rose 75%. As much as 29 cents of every health care dollar is currently spent on prescriptions; those costs are rising at 15% to 20% per year, and this trend is not slowing. One report indicated that drug costs are expected to increase as much as 94% over the next five years.

Ms. Anderson stated that other business costs are not rising as rapidly as medical plan costs. She noted that many EHCI member companies have been forced to shift costs by increasing employee premiums, deductibles and copayments. Many have moved to a 3-tier copayment structure with a formulary for prescription drugs. Many have ensured efficiencies both internally and with insurance partners to reduce administrative costs. Only 29% of the companies provide retiree coverage currently. Of those in the EHCI that do provide retiree coverage, some have capped the company contribution or are providing retiree coverage on a retiree-pay-all basis only. Many members have implemented wellness programs or added wellness benefits to the medical plans. Some are using health risk appraisals to assess data from their employees to further define their wellness programs. Some are stepping into the disease management programs to attempt to ensure that those with chronic illnesses get the necessary treatment now to lessen complications with higher costs in the future. Possible future changes include: capping transplant benefits, not allowing spouses who have access to other employer coverage to enroll in their plans, require that all maintenance drugs be provided by a mail order facility, reduce other benefits (dental, vision) to preserve medical coverage and ensure physicians follow evidence-based medicine for treatment of chronic illnesses. More possible future changes include: identifying disease management programs and continued cost shifting to employees through premiums, copays and coinsurance. Some members are very concerned that they are reaching the limit, especially as costs rise in the next few years and may have reached a saturation point for what their employees can absorb.

Colleen Brenton, representing Micron Technology, Inc., stated that in the past several years, increasing health care costs make it difficult for Micron to compete in the marketplace. Micron has employees around the world and must weigh many variables, including labor costs and benefits, when making decisions about the size of their workforce in each state and country. In many of their facilities outside the U.S., total payroll costs, including benefits, are much lower than in the U.S. Since 1998, Micron has consistently experienced double-digit increases in annual medical costs in the U.S., resulting in an increase in per-employee medical costs of more than 100% in the last five years. In spite of their efforts to improve efficiency in administering benefit plans both internally and in conjunction with their third-party providers, they expect these increases to continue at a double-digit level. Drivers of the cost increases include:

- Increased demand by consumers for increasingly expensive prescription drugs and medical services;
- Expensive new technologies that do not necessarily result in more efficient clinical pathways for care;

- Excessive capacity and duplication of medical services; and
- Federal privacy regulations which have created an expensive bureaucracy of notices and consents and have resulted in additional requirements for technology.

Specific to Idaho, the increase in the uninsured population and level of funding for the CHIP and Medicaid programs have contributed to increased costs for care which are passed on to employers through fully-insured or self-insured plans. This is because the care provided to the uninsured population (the vast majority of which are the working poor) must be paid for somehow. We all need to be concerned with the balance of how these costs will be paid as well as who will pay for them and be sensitive to increasing costs for employers already under cost pressure.

Ms. Brenton state that in addition to personal medical care insurance, Micron provides, as do other employers in Idaho, worker's compensation benefits for employees injured at work. The worker's compensation system also suffers from cost increases. Some are due to the same issues raised above. In addition, Micron is concerned that the worker's compensation coverage may become subject to a creeping expansion into injuries that are not the result of work. It is important that the worker's compensation system continue to be a resource for treating work injuries only, while employees remain accountable for their personal health issues. It is also important that the system be efficient in treating these work-related injuries so as not to add to the increasing costs of doing business in the state.

Despite these cost increases, **Ms. Brenton** stated that Micron will continue to provide competitive benefits in order to attract and retain the quality employees. Nevertheless, they have been forced to pass on some medical cost increases to their employees through increased premiums and other plan changes. What is needed for the benefit of employers, employees and Idahoans in general is a rational medical economy with a reasonable rate of cost increase. Because of these concerns, one of Micron's long-term goals is to address the whole picture of health care costs so that increases are contained or at least held to a reasonable level.

Senator Cameron inquired with regard to the trends in increases in other states and asked for data from **Ms. Brenton** regarding how Idaho compares to other states in which Micron does business. **Ms. Brenton** answered that the trend is very comparable around the country.

Mr. Jim Stark, representing the Boise School District, stated that he is the Insurance Supervisor and Co-Chair of the District Joint Insurance Committee and has been with the Boise School District for 18 years. He noted that in 1981, the insurance rate was $41; for less coverage today, the cost is $398, representing about an 800% increase. During that same time period, the salary increase for a beginning teacher was 67%. The contrast is phenomenal. He stated that a custodial

employee who averages about $12,000 per year in salary has trouble covering family insurance coverage costing over $10,000 per year; consequently they have some employees with negative paychecks.

Mr. Stark continued by stating that the Boise School District is struggling. This year, for the first time in its history, the district had a decrease in total revenue. At the same time that they lost $2,000,000 in revenue, the increase in their health insurance required $1.7 million dollars in new money. The district watered down the plan and shifted some costs to employees. If the employee has a medical situation, they must come up with more than $1,000 out of pocket. The district is doing everything it can to control costs. Total administrative costs for the district are 8%, which include the state premium tax and the cost of processing claims. The other 92% of its insurance dollars go toward incurred medical costs. The average age of employees in the district is 48, which is a very senior population with over 70% female employees. Females cost more to insure for medical reasons, and it costs three times as much to insure a 40 year old than it does to insure a 20 year old. The Meridian School District pays less for coverage because it has younger employees.

Mr. Stark noted that the Boise School District just signed a three-year contract with their teachers for frozen salaries for the next three years; at the same time the medical costs are continuing to go up. Family coverage costs $916.50 per month. Health benefit costs are expected to sustain increases of over 15% per year for at least the next five years. The district covers 5,000 insured members, and as one of the largest employers in the valley, it struggles to provide reasonable coverage that protects the health of the people it covers. When employees cannot afford dependent coverage, and when there are no salary increases, it is hard to meet the goal of "recruiting and retaining quality employees." In a survey last year, teachers put protecting benefits as their top request, *above salary*. This year the district will spend $15 million on employee health insurance. The District is willing to join in any effort to find solutions that will provide quality, affordable insurance coverage so their employees can focus on education. **Mr. Stark** added that the district only pays for employee coverage for full-time employees. For employees with dependents, family coverage is equivalent to 24% of a starting teacher's salary. He passed out a two-page handout (available in the Legislative Services Office) including charts showing insurance increases compared to salary increases and starting teachers' salaries and insurance costs from 1998 projected through 2006.

Cindy Anderson, representing Idaho Power, stated that between 1997 and 2002, the total cost of health care (employee and employer combined) increased 60%. Prescription costs rose 90% during that same period. Traditionally, Idaho Power has provided retiree medical coverage, but adjustments have been made in response to the cost of that coverage. In 2002, Idaho Power capped the company's contribution at 2002 spending levels, so as costs go up, retirees will absorb that full cost increase. This has affected 2003 premiums, and premiums for 2004 retirees are projected to reflect an increase of about 50%. Those hired after January of 1999 will retire with the option to participate in a group health insurance plan, but they will pay 100% of that cost. Originally, Idaho Power did not intend to make a group plan available to retirees hired after

January of 1999; however, this decision was changed because Idaho Power found it was no longer competitive for mid-career hires.

Ms. Anderson stated that Idaho Power has added wellness benefits to medical plans, and cardiac risk assessments are provided every other year to reduce health care costs in the future. The average age of Idaho Power employees is 42 years old. Idaho Power experimented with a prescription education campaign and provided a newsletter specific to the high cost of medications being utilized under their plan; they provided information about lower cost alternatives and set goals to reduce prescription costs and communicated those goals to their employees. Idaho Power compared their first quarter costs of 2003 to 2002 and concluded that the education of their employees did have some effect: the rate went down about 4%. Currently, the rate is about 11%, and their third-party administrator considered that to be very good news. Idaho Power is working with the EHCI to educate themselves and their employees about health care issues, but they need to plan strategies to stabilize costs.

Heidi Kilian, representing DirecTV, a subsidiary of Hughes Electronics, spoke next. She noted that in Idaho, Hughes DirecTV employs about 1,700 individuals who staff their customer care center. The center is critical to the operation of DirecTV and is unique in its employee population in several ways:

- The average employee age is very young at 32, in comparison to 42 for Hughes overall.

They employ about 3,500 nationwide.

- Medical and disability claims experience for this group is significantly higher than the experience for other geographic locations.
- Disability experience is five times higher.
- The Boise population equals 20% of their company population, yet incurs 30% of the medical and pharmacy expenses.
- In 2002, the average per surgery cost tracked for their total population in the Hughes Medical Plan through Aetna was $236. In Boise alone this cost was $628.
- From April, 2002 through March, 2003, medical and pharmacy claim expenses for Boise alone were $5.6 million.
- Studies show that productivity loss from absenteeism (for lost work) and presenteeism (for impaired performance on the job) could be costing Hughes up to three times this amount.
- Poor medical/disability experience in Idaho is driving up overall cost and premium trend increases across the company at Hughes.
- Actions have been taken to target the current and potential work-related and lifestyle health risk problems that are affecting the health of this group.
- The most costly health claims categories are:
    - musculoskeletal problems
    - arthritis

    - low birth weight babies
    - pregnancy complications
    - gallbladder disease
- A recent health risk appraisal showed that lifestyle issues were a large factor:
    - 22% overweight
    - 19% smoking
    - 21% at risk for high cholesterol
    - 14% reporting high blood pressure
- These percentages are uniquely high compared to the overall Hughes population.

Ms. Kilian stated that Hughes has recently undertaken an innovative program with the Health and Productivity Corporation of America to analyze medical claims and work with local providers to improve treatment patterns and impact medical/disability care and costs. Hughes also has other employee incentive and education programs to help reduce health risks for their employees company-wide. Hughes sees an opportunity for Idaho to make an impact in two basic areas:

- Supporting employers in their efforts to improve health care delivery to their employees.
- Realizing that the lifestyle health risks Idahoans are incurring in general may require action and education beyond what can be provided in an employer setting.

She stated that Hughes DirecTV encourages the legislature to investigate trends in health care utilization and treatment patterns, and to benchmark those in Idaho against those of other U.S. regions. Idaho is seeing potentially preventable illnesses related to lifestyle that are well beyond the norm. Health education must be a priority that extends beyond the work setting.

Senator Kennedy pointed out that Boise's employee surgery cost, compared to nationwide, is about 3 to 1, and asked what could be causing this discrepancy. **Ms. Kilian** responded that the company does not know, but that it is looking at the claims and information on an aggregate basis to figure out the cost drivers. **Ms. Kilian** stated that she would gather more information on this statistic, including how these numbers were gathered, and will provide that information to the Task Force at a later date.

Senator Kennedy requested that Micron provide the Task Force with a break-out of the relative costs and whether they are attributable more to prescription costs versus doctors and hospitals. **Senator Kennedy** asked if the Boise market was costing 2-3 times more than in other area markets? **Ms. Brenton** responded that Micron has had a similar experience based on their aggregate data and more information could be provided at a later date. **Senator Cameron**

requested that more information on this subject be provided to the Task Force, including opinions on what is causing this discrepancy. **Mr. Stark** responded that one-third of health care costs arise in each area of pharmacy, doctors and hospitals: hospitals first, doctors second, and pharmacy comprises about 20%. Insurance companies could give the Task Force more specifics but **Mr. Stark** shared that the trend over the last fifteen years has been very consistent, with hospital costs increasing the most.

Senator Cameron reiterated that the data provided indicates that the average surgery cost is much lower in other areas than in Boise, and asked where that data came from? **Ms. Kilian** responded that the data came from both Aetna and Blue Cross. **Senator Cameron** requested further data on this statistic.

Representative Collins inquired about insurance programs from the major corporations in Idaho and how they compare. **Dr. Pickford** responded that the ECHI included some of that in the aggregate data but agreed to work on this issue for the Task Force. **Senator Cameron** added that he has seen employers and employees who want to design a product or plans, particularly in the self-funded arena, that are sometimes not very cost-effective, and he invited input about how plans can be made more cost effective.

Dr. Pickford commented that the EHCI is continuing this health care discussion at its annual meeting on October 23rd. Hospital initiatives will be discussed, and evidence-based practices in medicine will also be presented by Blue Cross. **Dr. Pickford** added that the EHCI's November meeting will focus on a discussion of the framework for health care cost containment.

The next meeting of the Health Care Task Force was scheduled for November 12, 2003, at 9:00 a.m., in the House Majority Caucus Room. **Senator Cameron** stated that in December, the Task Force will address any legislative recommendations and invited the introduction of any draft legislation to be shared at that meeting.

The meeting was adjourned at 3:20 p.m.