To be approved by the Task Force

HEALTH CARE TASK FORCE
MINUTES

Wednesday, June 1, 2005
9:00 a.m.
House Majority Caucus Room
State Capitol, Boise, Idaho

The meeting was called to order by Cochairman Representative Bill Deal at 9:05 a.m. Other task force members present included Cochairman Senator Dean Cameron, Senator Joe Stegner, Senator John Goedde, Senator Dick Compton, Senator Tim Corder, Senator Kate Kelly, Representative Max Black, Representative Sharon Block, Representative Gary Collins, Representative Kathie Garrett and Representative Margaret Henbest.

Others present were: Sam Blair, Insure Idaho; Leslie Clement; Randy May and Patti Campbell, Department of Health and Welfare - Medicaid Division; William Rainford, Catholic Diocese of Boise; Joe Gallegos, Ken Thorson and Maribeth Connell, AARP; Steve Millard, Idaho Hospital Association; Woody Richards; Bob Seehusen and Molly Steckel, Idaho Medical Association; Mark Banks, Norm Varin and Tim Olson, Regence Blue Shield of Idaho; JoAn Condie, Idaho State Pharmacy Association; Joan Krosch, Gary Smith, Phyllis Stephenson and Shad Priest, Department of Insurance; Lois Bauer, Idaho Commission on Aging; Kate Vanden Broek, St. Alphonsus; Amanda Brown, Service Employees International Union 687 (SEIU687); Karen McWilliams, J.L. Byington and Krista Ziebarth, Idaho Community Action Network; Elwood Kleaver, Primary Health; Representative John Rusche; Roger Sherman, United Vision for Idaho/Insure Idaho; Julie Taylor and Jerry Dworak, Blue Cross of Idaho; Ken McClure, Givens Pursley; Lynn Darrington, Gallatin Group; Mike Kane; Scott Leavitt; Hyatt Erstad, Chairman, Idaho High Risk Insurance Pool; and Steve Tobiason.

After opening remarks from the Cochairmen, **Phyllis Stephenson**, Department of Insurance, was introduced to give an update on the Benchmark Survey. **Ms. Stephenson** explained that the Benchmark Survey began in 2001 due to the change in rate bands that took place in 2000. These rate bands changed from plus or minus 25% to plus or minus 50%. Due to this expansion it was decided that information needed to be collected to see what effect the change had on the small employer insurance market.

Ms. Stephenson first explained a chart showing overall enrollment including small group, individual, large group and total enrollment, from 1998 to 2003. She stated that in her opinion, 2001 was a transition year because that was the year after the rate bands were expanded.

Ms. Stephenson explained that both individual and small employer enrollment increased at least until 2003. In comparison to the overall Idaho population, the individual and small employer coverage makes up from 6% to 7% of the entire population. **Ms. Stephenson** noted that the information the survey was collecting included overall individual enrollment in the top five products by carrier. Her study used the top products of three carriers. Unfortunately, the products are different for each carrier so comparisons are more difficult. The chart does show that overall enrollment had decreased since 1999. This information also shows that for an individual male aged 25 for each of the same three carriers, the premium has increased since 2000.

Ms. Stephenson went on to explain how individual enrollment was distributed according to risk. The information gathered showed that in 2003, there was very little enrollment in the high risk category. Most of the enrollment is from the low risk people. The same trend is true for small employer enrollment.

Senator Cameron stated that he would like to see comparisons of more similar products for the three carriers for future meetings. **Ms. Stephenson** said she would try to do that. She added that the 2004 information would be available this fall.

In response to a question from **Senator Compton**, **Ms. Stephenson** explained that in July 2000, the rate bands were expanded from a plus or minus 25% to a plus or minus 50%. This expanded the price ranges that a carrier could charge for a product. The 25% rate band was basically a 6% to 7% spread between the lowest business rate and the highest business rate a carrier could charge. The 50% rate band is a 200% spread. This is for new business.

Senator Cameron noted that at the time the rate bands were changed, there was some controversy. The original rate bands were designed to allow carriers some variance on what they could charge individuals based upon their health condition. The index rate becomes the middle with the minus 25% being a discount given for healthy individuals and the plus 25% being charged for less healthy. At that time, each carrier interpreted this differently and most went to a tier level, rate band rating system. The argument was that with the 25% bands, the carriers were having to charge the healthy people more to help pay for the less healthy.

Representative Henbest noted that there has been a 10% growth in overall

population from 1999 to 2003 and a 10% growth in small employer group market insurance enrollment. **Ms. Stephenson** said that she did not look from 1999 forward; she did each year individually. She added that from 2002 to 2003, there was almost a 2% increase in overall Idaho population and about a 2.5% increase in small employer group enrollment, while individual enrollment was about 1.5%. **Representative Henbest** explained that the argument during the discussion of changing the rate bands was that expanding them would bring more healthy lives into the marketplace and would lower the rate of uninsured. According to this information, it does not appear that huge progress has been made in this area. **Ms. Stephenson** said it is difficult to say what the impact of the rate band changes had on this because there are a lot of other factors that need to be taken into consideration.

Senator Cameron moved that the Department of Insurance collect the 2004 data and, for comparison purposes, use products from the carriers that are as similar as possible. The motion carried unanimously.

Representative Henbest suggested getting recommendations from the Department of Insurance as to what information should be collected in order to give the best analysis of what is actually going on in the marketplace.

Lois Bauer, Idaho Commission on Aging, was introduced to give an overview of Medicare Part D. **Ms. Bauer** explained that prescription drug costs were one of the main driving forces in this change. The actual program takes effect on January 1, 2006. In the meantime, Congress put a stop gap measure in place in the form of a short-term pharmaceutical discount card program. This program has proven to be very confusing and, according to **Ms. Bauer**, each time publicity was released, the Commission received numerous calls. Even the simplest forms were very confusing. Websites have been set up to help, but many seniors either do not have access or do not feel comfortable using computers.

According to **Ms. Bauer**, the State Health Insurance Benefits Advisors (SHIBA), in just the last 11 months, have had 3,000 calls specifically relating to the drug cards. For Area 6 in the northeastern part of Idaho, from January 2004 to March 2005, $39,297 in additional expenses have been incurred just to help people sign up for the discount cards. Area 6 is estimating that it will cost approximately $120,000 to get people signed up for the new Medicare Prescription Drug Benefit Package, commonly referred to as Part D. It is estimated that it will cost over $800,000 for the Commission on Aging and its area agencies to do their part to get people registered in Idaho between Nov 15, 2005 and May 15, 2006. It is estimated that there are at least 155,000 people in Idaho that are eligible for this program. It is not just for low-income individuals.

Ms. Bauer stated that it is difficult to explain the actual Part D program itself because it is still being developed. Changes are being made frequently. November 15, 2005 is the date that sign-up actually begins. People that are low-income or on Medicaid can register today, but that does not mean they are being signed up.

In response to a question from **Senator Stegner**, **Ms. Bauer** clarified that the Commission on Aging is not mandated or responsible to sign people up for this program. The Commission is taking on the responsibility because seniors are going to need help. She continued that the $800,000 figure was mentioned to inform the Task Force that an unfunded mandate is coming from the federal government. CMS and Social Security are getting some funding for this, but the Aging Agencies are not.

Representative Garrett commented that she requested that **Ms. Bauer** be put on the agenda for the meeting in order to inform the legislature of what is going to be happening with this Part D program. This will affect other agencies besides the Commission on Aging. This involves 183,000 of the state's most vulnerable individuals and in many cases prescription drugs are a life-sustaining issue.

Senator Compton added that he attended a conference in Washington, D.C. that was supposed to include an explanation of Part D. He said that almost no explanation was given and he left with more questions than answers. It is very frustrating.

Ms. Bauer suggested having the Department of Health and Welfare speak to the Task Force because Part D is going to be difficult for them due to the many regulations and requirements they face. She stated that they are doing a fiscal analysis to project what this will cost and this information might be helpful to the Task Force.

Ms. Bauer concluded by stating that the changes in Medicare will affect the services provided by state government. The state will be providing some of the assistance that should be provided through the CMS and Social Security agencies. In her opinion, doing this is important because the benefit to seniors that want to remain independent is greater than the costs involved. Without getting people at risk onto the Medicare Part D plan, these individuals will overspend what resources they do have and end up on Medicaid.

Representative Garrett explained that this involves 183,000 citizens and about 23,000 of those are dual-eligible. This means that they qualify for both Medicaid and Medicare Part D. People that a dual-eligible will be receiving letters informing them that they qualify for this program. **Representative Garrett** said that she

agreed that the forms are very confusing and these people will call the people they are used to getting information from regarding their insurance or prescription drug coverage. Not all of the plans cover all drugs and it is estimated it will take 30 minutes to 1 hour to enroll.

Representative Garrett continued by stating that in October, the Social Security Department will send letters to everyone 65 years or older regarding the program and explaining what the options are. Insurance companies are also supposed to be sending letters to their senior customers explaining whether their current insurance coverage is better or equal to the Part D plan. Once these letters are sent out, the questions will start coming in. There have been some regional planning groups formed to help with this.

In response to a question from **Senator Goedde** regarding SHIBA, **Mr. Gary Smith**, Department of Insurance, explained that it is funded through federal funding with a state match. He said that providing answers to these questions and getting people registered is going to fall back on SHIBA and the network of volunteers. If each registration takes 30 minutes, that is about 10 people per day. More help is needed.

Representative Garrett explained that groups in each of the regions are looking at identifying volunteers such as college students majoring in social work or health care to help. They are also looking for places such as libraries or schools with computers to use to help get people signed up.

Representative Henbest said that in a spring meeting with regional representatives of CMS, it was stated that the woodworking effect that is being anticipated for Medicaid is as large as the CHIP woodworking effect by a ratio of 3 to 1. This means that for every one person that is going to be enrolled in the Medicare Part D benefit, there will be three people enrolled in Medicaid. In her opinion, this has huge implications for the state Medicaid budget as well as many other agencies. **Senator Cameron** noted that there is a place on the JFAC spring meeting agenda that is designated for Medicaid. He was unsure whether the Medicare Part D and woodworking effect were going to be discussed but said he would make sure they would be discussed at the fall meeting, if not before.

Ms. Patti Campbell, Department of Health and Welfare-Medicaid was introduced to give an update on the Access Card for Adults and Children. She explained that her presentation would include three programs that were generated from House Bill 376 in the 2003 legislative session. Those programs are as follows.

- CHIP-B - Implemented July 2004

This program is a direct state coverage program but it does not provide the full array of medical services that other programs do. This program does include a cost share component of $15 per person per month and covers children through the month of their 19th birthday.

♦ Access Card - Implemented July 2004

This program provides premium assistance for people to purchase their own insurance by providing $100 per person per month with a maximum of $300 per month per family. This money is provided by the state directly to the carrier. The family is responsible for co-pays and deductibles of whatever plan they select, either group or individual. This plan also covers children until the month of their 19th birthday.

♦ Access to Health Insurance - Begins July 2005

This is similar to the Access Card in that it provides premium assistance for adults who work for small businesses (2 - 50 employees). With this plan the employer must agree to offer health insurance to the employee and to pay 50% of the adult premiums. After that, the plan will pay up to $100 per employee, spouse and children up to a maximum of $500 per family. Since this is a pilot program it is limited to 1,000 adults (employees and spouses) with a priority for participation based upon the date and time of on-line registration that began May 16, 2005. To qualify for this program, the family income must be below 185% of the federal poverty limit and the individual must not have health insurance at the time of application, must live in Idaho and must meet citizenship requirements. Also, to qualify, their assets must be less than $5,000 for CHIP-B and the Access Card.

Ms. Campbell explained that the requirement that they not have health insurance is true for all three programs and comes from the funding source that is a Title 21 source in which the state gets an 80% match from the federal government. She added that the other 20% of the funding comes from the Idaho Premium Tax fund, not the general fund.

In response to a question from **Representative Black**, **Ms. Campbell** explained that the $5,000 in assets does not include housing and the family is allowed two cars before cars are considered as assets.

Ms. Campbell stated that there are fewer than 2,000 people enrolled in the CHIP-B and the Access Card programs from about 9,000 applicants. The denial rate has been very high and she noted that the top three reasons for denial are high of

income, assets over $5,000 or that they have insurance at the time of application.

Representative Henbest said that she has heard from others that the asset test is a significant barrier to enrolling more people and asked if that was true. **Ms. Campbell** said that was a valid complaint and stated that the new Access to Health Insurance program does not include that as a requirement. She said the asset test for the CHIP-B and Access Card is being evaluated currently and stated that most of the asset tests that fail are only slightly over $5,000. Changing this would require a recommendation from the Legislature that the rules be changed regarding the assets test. **Representative Henbest** suggested that be discussed at the next meeting.

Senator Cameron asked if having existing insurance at the time of application was the largest reason for denial and, if so, could other title money be used to eliminate this requirement. **Ms. Campbell** said that the Department could request a waiver to use different title funding such as Title 19 that is a 70% match rate. This is currently being considered. In response to another question from **Senator Cameron**, **Ms. Campbell** said it is possible to fund the children that do not have insurance under Title 21 and those that have insurance under Title 19.

Senator Compton asked for **Ms. Campbell's** assessment of these programs and if they should be expanded. **Ms. Campbell** said that, in her opinion, these are very good programs. She stated that she cannot figure out why the enrollment numbers are so low for the CHIP-B program. It could be an education issue. In her opinion, the Adult Access to Health Care plan is great because there is nothing else like it available. From the number of people who have registered interest in the program in two weeks, it would seem that people are very interested in it. She continued by stating that the main barriers to the Access to Health Care plan are the cost to employers and the requirement that they provide 50% of the employee and spouse premiums.

Senator Cameron stated that he would like information regarding the amount of premium tax that was received that would be the state's 20% match. **Ms. Campbell** said that there is $1.7 million in the premium tax fund for 2006. This includes adult and children's coverage. **Senator Cameron** clarified that the state has not even come close to maximizing this funding. The $1.7 million is the state share and that amount has not even been spent totally in the program. In his opinion, the programs could be expanded or some of the barriers could be reduced and the state would still be within the funding limits. He suggested more discussion of this at a later meeting.

In response to a question from **Representative Garrett**, **Ms. Campbell** said that of

the number of qualified applicants, the number that also qualify for Medicaid is not as high as expected. She said she would get that report to the Task Force.

Julie Taylor, Blue Cross of Idaho, introduced **Jerry Dworak**, Senior Vice President and Marketing Officer for Blue Cross of Idaho, to discuss market trends. **Mr. Dworak** explained that when discussing market trends in health insurance, most of the conversation involves cost. Health care costs make up about 15% of total payroll for employers who provide coverage for employees. Health insurance costs are rising at a rate of 4 times the general GDP and 5 times the rate of pay increases.

Mr. Dworak explained that Blue Cross has projected the average cost increase in premiums to be about 13%. Their increase varied from about 10% to 12%. For Idaho, the health care premium costs were actually lower than the rest of the region in which the state is grouped including Montana, Colorado, Wyoming, Nevada, Arizona and New Mexico. Idaho is approximately 12% below the rest of the region and about 20% below the rest of the nation. In response to a question from **Senator Cameron**, **Mr. Dworak** said that if administrative costs were included in these comparisons, Idaho's costs could actually be 20% below the rest of the region.

Mr. Dworak explained that medical trend is what drives the cost. Trend is not inflation; it takes into account cost, cost shifting, technology and utilization. Costs, which includes the fees being paid to providers for the same procedures as last year at Blue Cross, have increased 4%. Utilization increased 3%. This is a result of people going to the doctor more often and having more tests done. Direct consumer advertising also contributes to utilization increases. Technology is the next factor. While technology contributes to allowing people to live longer, it is also expensive. This component increased 2%. Cost shifting is the final component; it increased 1.5%.

Mr. Dworak said that in order to lower trend, strategies need to be developed to help manage each of these components. Providers set their own fees and insurance carriers pay those fees. In order to save money, Blue Cross has developed a number of ways to pay providers that are not tied to retail price. In 1997, Blue Cross came out with a Preferred Provider Organization (PPO) through which customers get a discount if they go to doctors or hospitals that are part of the PPO. It worked very well in Idaho and provided an average savings of about 25%.

In response to a question from **Representative Henbest**, **Mr. Dworak** explained that the cost of pharmaceuticals is a separate entity but for this presentation he

included that in the cost component. He said that he would get the breakdown of pharmaceutical costs for the Task Force.

Utilization is the next component. **Mr. Dworak** explained that in almost all cases, 20% of the people use 80% of the benefits, so the focus needs to be on this 20%. Today the entity that is most able to manage people's health care is their insurance company due to the fact that people do not always have a primary care physician. Since people have to file claims, the insurance companies can track and identify people that are at risk for high cost claims. Then the carriers can develop plans for disease management. Managing the diseases before they get out of hand can save a lot of money. **Mr. Dworak** explained that they are encouraging providers to put preventative measures in the front end.

In response to a question from **Senator Goedde** regarding the effect advertising has on utilization, **Mr. Dworak** stated that studies have shown that 60% of the drugs used today are self-prescribed. People go the their doctors asking for specific drugs and the doctors prescribe them.

Technology is the next component. **Mr. Dworak** noted that technology is a great thing and it keeps people alive. On the other hand, it also contributes to utilization. One example of this is with imaging procedures. According to **Mr. Dworak**, the use of imaging procedures from 1998 to 2005 rose from 267,000 to 471,000. Blue Cross claims data shows that same trend. In order to limit this growth, Blue Cross has implemented a preauthorization program through the National Imaging Associates.

Mr. Dworak continued that cost shifting in Idaho is a huge issue. Idaho has a large population of uninsured and it is growing. This contributes to a lot of cost shifting to others. In order to combat this, Blue Cross developed a plan called Chamber Blue. This is a cooperative effort between providers, insurance companies and brokers. They asked these groups to offer a discount to try to get the uninsured into the system. This worked and the program offered is about 20% cheaper than the street rate for those that have not been insured for six months. This is offered exclusively to Chamber of Commerce employer members. This program emphasizes preventative care.

Mr. Dworak stated that the final initiative at Blue Cross of Idaho is quality. Just because the United States has the most costly health care in the world, this does not mean we have the highest quality of care in the world. Blue Cross has put $2 million in a pool for hospitals. If those hospitals make certain procedural changes, documental changes and safety changes to provide a better quality of care, they can share in part of this money. This money is coming from a Blue Cross corporate

surplus. They hope to expand this to the physician community next year.

Representative Henbest asked, regarding quality, how the average citizen finds out which doctors or hospitals have more reasonable rates. Mr. Dworak said that Aetna and some other carriers were the first to develop initiatives to address the quality issue. He noted that over the last six months, the medical directors of Blue Cross have been meeting to develop standards of quality with which to measure providers. These should be available sometime this month. The plan is to make this information available to the public.

Senator Compton stated that some other states have laws that require hospitals to post the costs for various procedures, and added that a Medicaid plan would look very similar to what has been discussed for private carriers. Twenty percent of the people still use 80% of the services. The challenges are also similar and that is to encourage health lifestyles and prevention of problems before they develop into more costly problems.

Mr. Dworak clarified that the uninsured data came from the U.S. Census Bureau. In response to a question from **Senator Cameron** about why Blue Cross thinks the uninsured population is growing, **Mr. Dworak** stated that the focus has been that the uninsured population is coming from the working poor. He added that a California study has shown that the uninsured population is actually coming from the high income and healthy population. This study showed that 32% of the uninsured in California have incomes over $50,000 and the fastest growing segment of the uninsured have incomes over $75,000. Seventy-five percent of the uninsured are employed, 40% are homeowners and 60% report having excellent or very good health. In his opinion, another factor that contributes to people being uninsured is an employer-based system that requires an employer to contribute a significant amount to cover employees and their families. In many cases this is too expensive and employers decide not to offer coverage and many families choose not to pay for individual coverage. Development of more non-traditional products is necessary in order to attract these people back to insurance coverage.

Representative Henbest commented that **Mr. Dworak's** presentation showed that Idaho has lower cost premiums than other surrounding states, but it also showed that Idaho is eighth in terms of its uninsured population. In her opinion, this shows that Idaho health insurance is still largely unaffordable.

Tim Olson, Regence Blue Shield of Idaho, introduced **Norm Varin** to continue the discussion of market trends in health care. He also introduced **Mark Banks** as part of the Blue Shield team in charge of compliance. **Mr. Olson** noted that **Lyn Darrington** of the Gallatin Group is still part of the Blue Shield team as a contract

lobbyist.

Mr. Varin stated that his presentation would include more general issues that are taking place in health care that affect Idaho and surrounding states. He said that people are uninsured today because it is unaffordable, not just in Idaho but across the nation. The average employee premium per family nationwide is $10,000 not including a deductible, co-insurance or copay.

Prevailing trends in health care are as follows:

- The number of uninsured people is increasing

Mr. Varin said that recent information shows the average uninsured population for the nation is about 18%; Idaho is around 20%.

- Aging population

There are about 35 million people in the United States that are over age 65 and in the next 25 years that number will double. Therefore, there will be increases in serious diseases such as cancer. In his opinion, the health care system is not prepared to handle that today.

- Insurance premiums are stabilizing

This means the rate of increase is predictable and fairly low. This does not mean they are affordable or decreasing.

- Cost trends still exceed the normal non-medical CPI by about 4 times.

Mr. Varin explained that the factors that are driving the increases in trend include general inflation (CPI), drugs, medical devices and medical advances (technology), rising provider payments, increased consumer demand, government mandates and regulation, the impact of litigation and risk management. **Mr. Varin** explained that trend is the annual change in cost from one year to the next and noted that since his presentation did not specifically address this issue, these factors might be discussed in depth at a future meeting.

Mr. Varin continued by stating that employers, the government and carriers all respond to the prevailing trends. The employer response is important because about 65% of Idahoans are under employer insurance, while fewer than 10% are in small group or individual coverage. The majority of what is driving decisions about health care is coming from the employer market.

Mr. Varin noted that employers' historical response to rising costs has been to pass it on to the employee through increased premiums, increase out-of-pocket amounts, providing self-care information or reducing or eliminating coverage altogether. The new response by employers has been to band together and take a public stance demanding quality care. Today employers are becoming more involved in employee health. Employers are also moving toward a more consumer-directed health care. According to **Mr. Varin**, one Northwest company has reached an agreement in which its employees must earn points for leading health-conscious lifestyles; those who refuse to complete a confidential health questionnaire or fail to earn enough points must pay substantially higher rates for health care coverage. In his opinion, this is something that is going to become more and more common.

Mr. Varin continued that the government response to rising costs has been to start offering health savings accounts. It is estimated that about 32% of large employers will be offering some sort of health savings account product to employees. The federal government is also trying to give people tax credits for signing up for health savings accounts. Another government response includes mandated coverage. This means mandated universal health care coverage. Maine passed an act in 2003 that is expected to cover all of their residents by 2009. California and Massachusetts also have similar legislation. Uninsured subsidy programs are also a response by government to rising health care costs and will continue to expand. Lastly, **Mr. Varin** noted that HIPAA continues to play a role in stemming the cost of health care and will play a larger role in the future regarding electronic medical records.

Mr. Varin noted that Medicare is developing a pilot program for doctors and hospitals to pay for hospitals. Some of this standardization has shown positive impacts. In his opinion, if Medicare is doing this, it will trickle down through the system.

The carrier response is very similar to the others. It includes more emphasis on the consumer-directed health care. According to **Mr. Varin**, all carriers in Idaho have some form of health savings account. Information transparency is something the Regence Blue Shield is dedicated to. In their opinion, consumers have been insulated from the actual cost of health care and, in the future, information will be available to show consumers exactly how much it will cost them for certain procedures. Another response by carriers is more proactive involvement in patient care. This means paying attention to a person's health before it gets serious.

Mr. Varin summarized that overall, the system needs to be simplified by providing transparent information so everyone knows how much it will cost for health care. Another way to simplify is through innovative solutions that may not be allowed

under current laws. The final step to simplifying is accountability. Everyone that uses health care needs to be accountable.

Senator Corder asked who bears the greatest burden of the shift as a result of the uninsured. **Mr. Varin** explained that cost shifting comes largely as a result of what Medicare and Medicaid reimburses the providers. Since provider costs are higher than what is received from Medicare or Medicaid, the charges the private providers pay are higher. Some of this expense is also written off as bad debt.

Representative Henbest commented that cost shifting also impacts the uninsured in terms of the bill they pay. This is because they do not have any ability to negotiate a discount. Thus, their bill is actually much higher than the bill for someone with Blue Shield or Blue Cross insurance, due to their negotiating power. **Mr. Varin** agreed.

In response to a question from **Senator Corder**, **Mr. Varin** said that about 7% to 8% of the market has individual coverage. These premiums are higher than small group or large group insurance, but because the benefits offered are less, the premiums can go down.

Senator Cameron clarified that depending on the product line offered, there are times when it is cheaper to be in the small group market rather than in the individual market. This has not always been true. There was a time when a number of small employers shifted away from small group coverage and encouraged their employees to purchase individual policies. The difference generally has to do with the rating and individual health conditions of the individuals in the group. In some groups, a young male would be able to get cheaper insurance with an individual plan. In his opinion, there is no attempt by the carriers to penalize people purchasing individual coverage. It is actuarially defined based upon utilization and health conditions. **Mr. Varin** said that to some degree there is an incentive for carriers to have more people insured to help cover the higher cost claims.

In response to another question from **Senator Corder**, **Senator Cameron** stated that carriers tend to group their products into pools that are fairly representative of either the product or the customer base they are trying to achieve, such as large group, small group or individual pools. This is one factor in the individual rate but another factor in that rate is the actual health condition and utilization of the individual. He has seen a number of situations where husbands and wives each have separate coverage due to one of them having a more favorable health condition and being able to get much lower premiums. **Senator Cameron** suggested that a more detailed explanation from the carriers as to how they develop their

rates be given at a future meeting.

Representative Henbest suggested discussing community ratings also. **Senator Cameron** explained that community rating had been done in the past but this seemed to penalize the younger, healthier people thus causing them to decide not to have health insurance. Community rating reduces the rate for the older, less healthy citizen and requires the younger, healthier citizen to pay more.

Laren Walker, Ameriben Solutions, gave the Task Force an update on the high risk reinsurance pool. He distributed a handout that included the balance sheet up to April 2005. A copy of this handout is available at the Legislative Services Office. He explained that Ameriben Solutions is the third-party administrator of health insurance plans in the western United States and for corporations and universities. They also administer the State of Idaho Individual High Risk Pool.

Mr. Walker explained that the high risk pool was formed in 2000 due to the challenges the state faced with the uninsured population. This pool was formed to address specifically some of the high-risk uninsured individuals that struggle to get coverage through a traditional insurance mechanism. The purpose for this pool was to create a stable funding mechanism for these high risk individuals. There is some subsidy that helps cover the cost of insuring these people.

Mr. Walker continued by stating that the funding mechanism provides for several different revenue sources. The first source is premiums. Carriers who have individuals in the high risk pool have the opportunity to reinsure these individuals into the pool. They pay an established premium for this reinsurance. The mechanism is through premium tax dollars. A portion of those dollars is directed to the program. If there is any shortfall after that, the final mechanism would be to assess insurance companies that do business in the state of Idaho.

Mr. Walker stated that due to the nature of the program, the claims can fluctuate dramatically. Currently, there are only between 1,300 and 1,500 people in the program but since they are very high-risk individuals, claims can be very high. The plan currently has excess cash available due to a study that was done that estimated how much money such a program would need to be able to effectively pay the potential claims.

Mr. Walker clarified that there are several different plans available to individuals as they look at the high risk pool. There is a Basic, Standard, Catastrophic A and Catastrophic B plan. The board is actually looking into introducing a type of Health Savings Account product into this pool. These plans range from a lifetime maximum of $500,000 to $1 million; the deductibles range from $500 to $5,000.

The premiums associated with these plans are actuarially determined annually and are a factor of the other carriers' premium rates.

Mr. Walker, in discussing the balance sheet, stated that as of April 2005, the program has $7,838,830 in cash and investments. The study that was done to estimate the amount of money needed to pay potential claims provided for $19 million. The liabilities in the plan include an estimated amount for claims that have been incurred but not reported (IBNR). This is actuarially determined at each year end. He clarified that this means that there are claims at the providers that the program is responsible for that have not yet been reported.

Mr. Walker explained that this plan also currently has about $6.9 million in deferred state tax funds. These are moneys that have been received into the pool from the premium tax dollars that have not yet been used by the program. These are available to be able to fund the claims that are coming in. This number is also felt to be low compared to what would actually be needed by the program. In response to a question from **Representative Henbest**, **Mr. Walker** explained that the reason the deferred state tax funds are listed as a liability is due to the fact that those funds are only there for the purpose of funding the program. If the program was shut down, those funds would probably go back to the state in some capacity.

Mr. Walker stated that the premiums that are paid by the carriers in order to be able to reinsure these individuals into the plan are coming into the plan at a rate of about $183,000 a month for a year to date of $712,000. This has grown since 2004. Claims being incurred are about $241,000 per month for a year to date of about $1.1 million. These numbers, compared together, show that if the program was relying on premiums alone, the program would be running at a significant deficit. Since January 2004, the lives covered under the program has been on a gradual incline from 1,300 up to about 1,500. In his opinion, a large majority of these people would not have insurance coverage were it not for this reinsurance pool.

In response to a question from **Representative Black**, **Mr. Walker** clarified that the high risk insurance pool is a reinsurance mechanism. In other words, the carriers are paying the front line claim and then they are submitting those to the pool for reinsurance.

Senator Goedde asked if the reserve for future known claims is included in the IBNR for the pool. **Mr. Walker** said that was correct. Each month the carriers submit claims to the pool and those are the current month claims expense. The IBNR covers the unknowns that might be sitting at the carrier or at the providers that have not submitted. **Senator Goedde** asked if any type of evaluation of claims was done. **Mr. Walker** said the evaluation was not done by the high risk pool. He

suspected that since the carriers pay the front line claims, they would do this.

Representative Henbest said that it was her understanding that these individuals pay a premium to a carrier and that the premium is then ceded to the high risk pool. **Mr. Walker** clarified that the premium the individual pays goes to the carrier and another premium is paid by the carrier to reinsure those individuals. The amount the carrier pays is less than what the individual pays to them initially for coverage. **Hyatt Erstad** explained that these rates are set by statute and all carriers pay the same rate. **Representative Henbest** asked if the carriers keep a small amount of these premiums for administration costs. **Norm Varin** said that 40% to 50% of the premium that is paid to the carrier has to be paid to the reinsurance pool for premiums. The remainder stays with the carrier but the carrier has a liability of about $7,500 per person. This money is used to pay claims up to that amount.

Mr. Erstad noted that the High Risk Board is made up of a great group of volunteers that includes consumer representatives, carrier representatives and people within the industry as well as legislators. With the help of the Department of Insurance, the Board runs in an extremely efficient manner and, in his opinion, this is a great program for the citizens of the state. The rates of this program are very competitive with the rates of the open market. He noted that one concern is that since actuarially claims costs are increasing, the pool is at risk for really large claims.

Representative Henbest said that even though premiums are competitive, they are relatively high. She said that some states with high premiums for individuals have added needs-based subsidies to their high risk pools. She asked if the Idaho pool has discussed that. **Mr. Erstad** said that it is his understanding that currently the rates fall within the median of all rates. **Mr. Varin** added that a person qualifies for the high risk pool if their rate exceeds the high risk pool plan rate, thus saving them money. These rates are actually set fairly close to the new business rates in the market.

Shad Priest, Department of Insurance, was introduced to give an overview of the Gem Plan. **Mr. Priest** explained that the Gem Plan is an employer-sponsored health plan. The most common type of employer-sponsored plan is where the employer purchases a health insurance policy that covers the employees and their families. In this case, the insurer takes on the risk and collects the premium. If the insurer becomes insolvent, the plan is still covered by the Idaho Guaranty Association.

Mr. Priest continued by stating that the second broad category of employer-sponsored health plans are self-funded plans. With this type of plan, the employer and employees pay money into a fund to cover the cost of the employee health

care benefits. In this type of plan, the employer essentially takes the risk of providing those benefits. Generally, employers hire a third party administrator to take care of administering the fund, reviewing claims, processing the claims and authorizing payment of the claims. In addition, in order to offset some of that risk, the employer usually purchases stop loss insurance that kicks in if claims exceed a set threshold amount.

Mr. Priest explained that the Gem Plan is comprised of a group of counties that have entered into a joint powers agreement to self fund health benefits for their employees. This type of self funded plan is sometimes referred to as a Multiple Employer Welfare Arrangement (MEWA). In the regulatory scheme, nearly all self funded health care plans are subject to federal oversight that consists mainly of voluntary reporting through ERISA unless they are sponsored by state or local government entities. Since the Gem Plan is comprised of a group of counties, thus local government entities, the Gem Plan is not subject to federal oversight.

Mr. Priest stated that Idaho's insurance code also contains a chapter that regulates self funded employer plans. This chapter requires that they register with the Department of Insurance, use properly administered trust funds to hold funds set aside to pay employee benefits, be actuarially sound and be subject to examination by the Department of Insurance for compliance. The Department of Insurance has taken the position that these state laws apply to both single employer self funded plans and multiple employer self funded plans. However ERISA (the federal law) says that states cannot regulate, as insurance, a single employer self funded health plan such as Albertsons or Micron. Multiple employer plans are regulated by ERISA, but because there were so many problems with these plans going broke or committing fraud, in the 1980s Congress passed a law subjecting these plans to both federal and state regulations.

Mr. Priest summarized that Idaho's self funded insurance chapter applies only to single employer plans not regulated by ERISA, meaning generally governmental plans and multiple employer plans. He noted that in 2001, Idaho passed an amendment to the self funded insurance code that exempted any self funded health plan administered by or for any county of this state from the registration requirement. In this case, the Gem Plan is not subject to state regulation either.

Mr. Priest stated that the Gem Plan operates pursuant to the joint powers agreement entered into by participating counties. The Department of Insurance's legal staff concluded that the Gem Plan is entitled to operate as a self funded, multiple employer plan and that they are not subject to state regulation as long as they only cover counties. Since the Gem Plan is not subject to regulatory oversight by the Department, Mr. Priest stated that he would not be able to answer

questions regarding the number of participating counties or their financial condition.

Senator Goedde asked if the Gem Plan would be characterized as a MEWA. **Mr. Priest** said that, as he understands the definition of a MEWA, the Gem Plan would qualify as one but since a MEWA is defined in federal law and the Gem Plan is not regulated by federal law, there are arguments that it is not. At this time, in Mr. Priest's opnion, there is no entity that actually oversees the Gem Plan other than the actual counties that are participating.

Representative Black asked what would happen under a regular multi-funded plan if one of the companies goes bankrupt. **Mr. Priest** said that typically the other companies would be obligated to continue to pay benefits for employees of the bankrupt company. It would depend on how the plan was originally designed. If a county were to drop out of the Gem Plan, it is Mr. Priest's assumption that coverage would cease, but it would depend on how the plan was designed.

Senator Cameron said that in reality the lack of regulation for this plan is not a good thing because most of the regulations are designed for consumer protection. He asked for clarification of consumer protection provisions and regulations that a traditional fully insured plan would have to adhere to.

Mr. Priest explained those protections would include prohibitions on preexisting condition exclusions. For someone coming from one plan to another, federal and state laws impose certain limitations on the plans ability to exclude conditions from coverage. If someone had coverage for a heart condition, they would be entitled to move into the new plan with the same coverage. Absent that protection, the plan can exclude that condition for a period of time as a preexisting condition. There are examples for coverage of newborns that immediately get into the plan without having a waiting period. **Mr. Priest** added that there are strict requirements for reserves even in the self funded arena.

Senator Cameron suggested having a discussion at a future meeting of the differences between fully insured, self insured and the Gem Plan and where the consumer protection issues are. He would like this to include issues such as mammogram coverage and the ability for plans to carve individuals out of coverage.

In response to another question from **Senator Cameron**, **Mr. Priest** explained that if someone had an issue with payment or nonpayment of claims and was covered by a single employer self funded plan, there is not much the Department of Insurance can do. The Department can help if they are covered by a multiple employer self funded plan or an insured plan. Once a plan is registered with the Department,

they have enough leverage to be able make sure such a plan is in compliance with the law. According to **Mr. Priest**, this is difficult to answer for the Gem Plan because the state enforces some HIPAA requirements but he is not sure if these even apply to the Gem Plan. In his opinion, state consumer protection laws do not apply to the Gem Plan since it is not regulated.

Senator Cameron asked if there were any known complaints that had been filed against the Gem Plan. **Mr. Priest** stated that as far as he was aware, there have been two complaints that had been resolved before they became formal complaints.

Senator Cameron said that one of his concerns has been the ability of the reinsurance carrier of the Gem Plan to carve out individuals or family members who may experience high claims. He asked if there are any disclosure requirements as to what is covered and how safe such a plan is. **Mr. Priest** said that the Department has no way of knowing the financial condition of the Gem Plan. He stated that in general terms the Department's experience with multiple employer plans has not been good. Requiring regulation of these plans, in his opinion, would be very helpful. Generally speaking, in **Mr. Priest's** opinion, an employee covered by a multiple employer self funded plan is not as secure as someone covered by a traditional insurance policy.

Senator Corder asked what would stop such a plan from voluntarily submitting to regulation. **Mr. Priest** said nothing would prevent this but there would also be nothing stopping them from withdrawing from the voluntary regulation. In response to another question from **Senator Corder**, **Mr. Priest** stated that a company could volunteer to have their financial solvency audited by the Department but if the Department told them they were underfunded, there would be nothing that would actually require them to do anything to alleviate the situation.

Senator Goedde noted that he remembered from a discussion with the Gem Plan people that there was an instance where they continued to cover someone that had been carved out by their insurance without the protection of the reinsurance pool. In his opinion, this could be disastrous. **Mr. Priest** agreed that is very risky.

Representative Henbest asked if the state employee health plan could opt out of the requirement to not carve out risk. **Mr. Priest** said it was his understanding that the state could opt out of those federal requirements.

Representative Black stated that it seemed that new legislation is the only way to actually require plans, such as the Gem Plan, to comply with regulations. **Mr. Priest** agreed.

Senator Corder asked what would happen if these plans were regulated and found not to have sufficient reserves. **Mr. Priest** explained that the practice is to sit down with the groups to address the problems while maintaining coverage for their employees.

In response to a question from **Representative Collins**, **Mr. Priest** said that the Gem Plan today is accountable to its members, county commissioners and the like. He would assume that those county commissioners would have an accounting firm look at the books to make sure the funds were solvent.

Senator Cameron suggested that the Task Force have full hearings regarding the issue of the Gem Plan. In his opinion, this is an issue that the Task Force needs to decide where that level of regulation needs to be. From his perspective, if it is decided that these plans do not need regulation, regulation of other carriers would also need to be looked at in order to treat all programs equally.

Bob Seehusen, Idaho Medical Association, was the next speaker. **Mr. Seehusen** explained that in the opinion of the Mental Health Task Force, mental health access and substance abuse treatment are hugely neglected issues in Idaho. In his opinion, this is the weakest link in Idaho's health care delivery system. He noted that in 2001, Idaho ranked 46th in mental health dollar expenditures with just $46 per capita spent. That same year Idaho had the 7th highest rates of suicide per capita, with 210 adults and adolescents committing suicide. Suicide is one of the consequences of undiagnosed, untreated and under treated mental illness. Untreated substance abuse increases the likelihood of a suicide attempt.

Mr. Seehusen noted that the Idaho Department of Correction reports that 26% of inmates housed in Idaho's adult prisons have a mental illness and 44% of all Idaho juvenile offenders managed by juvenile corrections have at least one mental health issue. Mental health costs the Idaho Department of Correction $1.34 million each year.

Mr. Seehusen continued by stating that while the population of the state has climbed in the past two decades, the number of inpatient psychiatric hospital beds at state hospitals has decreased and Idaho is designated as a Mental Healthcare Professional Shortage Area. The occupancy rate for Idaho state hospitals runs about 97%. As a result of the shortage of proper treatment facilities, emergency rooms end up seeing these patients at significant cost. In his opinion, in order to alleviate these issues, more crisis and 72-hour hold facilities are needed as well as more adequate funding for the Assertive Community Treatment teams. These teams could be used to monitor people once they are medicated and return home to make sure they are taking their medication properly. Home treatment is much more

cost effective than hospitalization. **Mr. Seehusen** stated that the cost of a private facility bed is $1,000 per day. A state hospital bed is only about $370 but with the shortage of beds, it is very difficult to get into a state hospital.

Mr. Seehusen distributed a handout, which is available at the Legislative Services Office, setting forth a list of priority needs as discussed by the Mental Health Care Task Force. These include the following:

1. More short-term beds for children and adults with mental illness
2. More long-term beds for children and adults with mental illness
3. More outpatient services for children and adults with mental illness
4. Focus on early intervention/prevention of mental illness for adults and children
5. Address court and legal issues
6. Workforce development issues

Mr. Seehusen stated that the Mental Health Task Force is asking the Health Care Task Force for its support in starting to address these issues and to be open to recommendations. He said that mental health and substance abuse are not popular issues but these diseases need to be treated with the same respect and urgency as cancer or heart disease. He said that the Mental Health Task Force is more than willing to work with this Task Force to explore the possibility of legislation to deal with these issues. According to **Mr. Seehusen**, up-front support from the Legislature for community-based intervention for mental illness and substance abuse would support a more humane approach to care, as well as the most cost effective treatment available.

Representative Henbest commented that with the current coverage that exists for mental health care, the priority list is filled with public dollars. She stated that as solutions are considered, shared financing would need to considered.

Representative Garrett said that physicians have expressed concern with the fact that there is no central agency that addresses these issues. She noted that there is a mental health coalition that is working together through interagency cooperation including the Department of Correction, Juvenile Corrections and Health and Welfare.
She continued that the Department of Health and Welfare under the Adult Mental Health Authority is applying for a federal grant to help formulate a statewide plan for mental health. This requires a cabinet-level committee from the Governor's office that has already met. **Representative Garrett** suggested having Ray Millar speak to the Task Force regarding the status of the transformation grant and what they have in mind for a state plan.

Senator Stegner suggested forming a subcommittee to review the list of mental health priorities. This subcommittee could consult with other interested parties and come back to the Task Force with findings and recommendations. Senator Stegner, Senator Corder, Representative Henbest and Representative Garrett were assigned to the subcommittee.

The next meeting of the Health Care Task Force was scheduled for July 8, 2005 in the Senate Majority Caucus Room. Items Task Force members suggested for discussion included mental health issues, a discussion of trends, the Gem Plan, Medicaid Part D, Chip-B qualifications, and a report on the high risk pool and the access card.

The meeting was adjourned at 3:30 p.m.