To be Approved by the Task Force

HEALTH CARE TASK FORCE
MINUTES
Friday, July 8, 2005
9:00 a.m.
Senate Majority Caucus Room
State Capitol, Boise, Idaho

The meeting was called to order at 9:05 a.m. by Cochairman Senator Dean Cameron. Other members present were Cochairman Representative Bill Deal, 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: Mary Lou Kinney, Covering Kids and Families (CKF); JoAn Condie, Idaho State Pharmacy Association; Pam Eaton, Idaho Retailers Association; Cathy Holland-Smith, Legislative Services Budget and Policy Office; Steve Tobiason, Idaho Association of Health Practitioners (IAHP), American Association of Retired Persons (AARP) and Idaho Association of Health Underwriters (IAHU); Ken Thurson, AARP; Molly Steckel, Idaho Medical Association; Jim Baugh, Co-Ad, Inc.; Nina Eng and Megann Holmes, Congressman Otter's Office; Bill Roden, Delta Dental and Pharmaceutical Research and Manufacturers of America; David Rogers and Patti Campbell, Department of Health and Welfare - Division of Medicaid; Suzanne Schaefer, National Federation of Independent Business; Elwood Kleaver, Primary Health; Darrald Bean, Idaho Association of Health Underwriters and Bean Insurance; Erin Bennett, Veritas Advisors; Sam Blair, Karen McWilliams, Emily Jones, Ron Matthews and Anna Walling, Idaho Community Action Network (ICAN); Woody Richards; Kate Vanden Broek, Saint Alphonsus; Steve Millard, Idaho Hospital Association; Tim Olson and Lyn Darrington, Regence BlueShield of Idaho; Julie Taylor and Dave Hutchins, Blue Cross of Idaho; Kathy Pidjeon, Employers Resource Management Company; Representative Nicole LeFavour; Sara Nye and Lauren Laskarris, Governor's Office; Joan Krosch, Department of Insurance; Jesus Blanco, Idaho Primary Care Association; Linda LaMott, Idaho Assocation of Health Underwriters; William Rainford, Roman Catholic Diocese of Boise; Teresa Molitor, Idaho Association of Commerce and Industry (IACI); Kali Carringer, Moons Kitchen and NFIB; Julie Fanselow, Idaho Democrats; Billy Knorpp, RVP Business Systems and NFIB; Lou Aaron, Westside Drive-In and NFIB; Rick Edvalsen, Intergrated Network Solutions and NFIB; and Deborah Johnson, Asphalt Systems Co., LLC. and NFIB. Staff members present were Caralee Lambert and Toni Hobbs.

After opening remarks from the cochairmen, **Senator Collins** made a motion that the minutes from the last meeting be approved as read. **Senator Compton** seconded. **The minutes were approved unanimously by voice vote.**

Patti Campbell, Department of Health and Welfare, was the first speaker. She was introduced to give an update of the Health Insurance for Adults and Children - CHIP-B, Access Card and Access to Health Insurance Programs as of July 2005. **Senator Cameron** said that due to the fact that there might be legislation proposed for the next session that might improve these programs, he plans to have **Ms. Campbell** give updates about the programs at each of the Task Force meetings.

Ms. Campbell recapped from the last meeting the major points of each program 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, the individual must not have health insurance at the time of application, must live in Idaho and must meet citizenship requirements. Also, to qualify, assets must be less than $5,000 for CHIP-B and the Access Card.

Ms. Campbell explained that the requirement the individual not have health insurance is true for all three programs and comes from the Title 21 funding 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.

Ms. Campbell explained the 2006 T&B budget that is appropriated for these three programs. She said the funding for these programs is slightly below 80% federal and state funding comes from the Idaho Premium Tax Fund. No general funds are used. The details are shown below:

Program	Premium Tax T&B Funding (21.06% of total cost)	Title XXI T&B Funding (78.84% of total cost)	Possible enrollees @ $100/month*
Access to Health Insurance	$262,900	$985,400	1,000
CHIP-B and Access Card	$1,465,000	$5,491,300	5,800
TOTAL	$!,727,900	$6,476,700	6,800

*Estimated based upon anticipated average of $100/month

Ms. Campbell reiterated that enrollment in the Access to Health Insurance for adults is limited to 1,000 people by state law.

Ms. Campbell also provided updated statistics for the CHIP-B and Access Card. She said there are currently slightly over 2,200 people enrolled in program. Most of these have elected the CHIP-B program. The total number of applicants since July 2004 is 9,607. About one-half of these were not eligible initially. She clarified that enrollment in these plans has been up to 4,500 but the total of 2,200 is as of June 30, 2005.

Denial reasons range from the following:

# of Ineligible Children 7/1/04 - 6/30/05	Reason Child Ineligible
986	Income too high
864	Open or eligible for Medicaid**
763	No Eligible Child***
703	Failure to clarify info
592	Assets too high
590	Creditable Insurance****
114	Medicaid Eligible (but did not elect coverage)*****
184	Other

4,797*****	

**Some individuals in this category were provided full Medicaid coverage; others were already open for Medicaid at the time of application.
***Denial reasons were not adequately identified in the computer system prior to mid-August. Most of the denials for "no eligible child" were due to creditable insurance coverage or open Medicaid coverage.
****The # denied for creditable insurance is higher than reflected. Many of those denied for "not eligible chile" are actually denied because of no creditable insurance.
*****CMS requires individuals who are entitle to Title ICI Medicaid coverage be approved for full Medicaid. Individuals denied for this reason wanted premium assistance of CHIP-B and did not want Medicaid.
****** The total # of denials will not equal the difference between total application and # enrolled as some individuals who were initially approved have closed or moved to direct Medicaid coverage.

Through June 2005, the year to date premiums collected through these programs was $153,511. The average monthly expenditures for CHIP-B has been $105.75 based on an average of expenditures in the last six months. Based on an average of April, May and June, the expenditures for the Access has been $71.88. **Ms. Campbell** said the access card expenditure amount has increased quite a lot since last month. This is partly because more claims have been received and some of those claims are more costly.

Ms. Campbell said that the Access to Health Insurance program is still in its infancy. The online registration opened May 16, 2005. This allowed agents or employers to register their intent to participate in the program. This was just to register their intent and to reserve the number of employees the employers think may want to participate. Since that opened, 135 employers have registered and the number of actual participating employers is eleven. Eleven employers have also decided not to participate due to the high cost of the insurance to them. She said it takes about two months to complete the process. They register their intent to participate and complete the insurance application as well as an application to the division to determine eligibility. Next, the underwriters determine the actual cost and the Department determines the eligibility for each participant. The employer then goes the actual agent who has information from the underwriter including the costs and the number of people eligible and the decision is made whether or not the employer wants to participate.

From the applications that have been received, 60% are from adults. One hundred thirty-five people have been denied, of which 82 were adults and 53 were children. There are 94 applications pending. **Ms. Campbell** said that income is again the number one reason for denial.

Senator Cameron said that even though the amount needed to fund these programs from the premium tax is $1.7 million, the Department has received more than that from the premium tax distributions totaling about $6.5 million. He said he would like to know what is happening with the remainder of that money. He noted that the state has almost $5 million for which it is not

receiving the 80% federal match. **Ms. Campbell** said she would get that information for the Task Force.

Senator Cameron stated that the CHIP-A and CHIP-B Bridge programs were designed for individuals to pick up while they were trying to buy other coverage. He asked if this was happening. **Ms. Campbell** said that initially these people did move to the CHIP-B program but now it is about fifty-fifty. Some are moving to the Access Card and some are remaining on that direct coverage program.

In response to another question regarding the number of inactive employers from **Senator Cameron, Ms. Campbell** said that there has been a lot of discussion that requiring the employer to pay 50% of not only the employee's premium but also for the employee's spouse is too high. She said she would get specific information. **Senator Cameron** suggested that the Task Force address future adjustments in this plan.

Ms. Campbell clarified that the 1,000 enrollment limit was met about ten days into the registration period. She said there are approximately 1,400 reserved spots available. This does not mean they are all eligible; it just means the employers have reserved slots for these employees should they qualify.

Senator Compton asked for recommendations from **Ms. Campbell** regarding expansion of the program. **Ms. Campbell** stated that based upon the response they have received from possible participants, requiring the employer to pay 50% of the premium for the spouse is more restrictive than a traditional carrier requirement. Her suggestion would be that the plan be more consistent with that of a traditional carrier requirement. She also suggested removing the requirement that the employer not have health insurance coverage for their employees in order to qualify for the access to health insurance program. Many employers have employees that would qualify for this program but because the employer is currently offering insurance, they are automatically disqualified.

Senator Goedde asked how long an employer has to drop coverage in order to qualify for this plan. **Senator Cameron** said he thought it was thirty days but that they cannot have dropped the coverage for purposes of obtaining this coverage. They have to have dropped it because their current coverage was too expensive. **Ms. Campbell** clarified that there is not a thirty day limitation; it is just required that they do not have insurance at the time of application. She added that if they say they dropped other coverage to qualify for this program, there is a six month waiting period. If they dropped for other reasons, such as cost, there is no waiting period. **Senator Goedde** suggested removing the requirement that they have to drop existing coverage in order to qualify for this program. **Senator Cameron** agreed, but noted that this is a CMS rule that would require federal action. He said that using Title 19 funds offering a 70% - 30% match would eliminate that requirement.

In response to a question from **Representative Henbest, Ms. Campbell** said that she would get the information for the Task Force regarding the people who are denied CHIP-B coverage due to

being over the income requirement and how much they are over that requirement. She said that the CHIP-A, CHIP-B and the Access card are all funded out of Title 21, and that is where that restriction comes from.

Senator Cameron introduced the small business panel including Billy Knorpp, RVP Business Systems, Lou Aaron, Westside Drive-In, and Rick Edvalsen, IntegriNet Solutions.

Suzanne Schaefer, NFIB, said that she appreciated the opportunity to let these small business owners speak to the Task Force regarding health insurance. There is no issue more important to small business than health insurance coverage. She explained that the three panel members have been very involved and have worked on the issue at the state and federal levels. She distributed a listing of key priorities gathered from a survey of NFIB's 700,000 members and said the number one issue on the list was health insurance.

Ms. Schaefer noted that small businesses in Idaho are almost 50% of the workforce and have provided almost 50% of the new jobs in the last two years. At the same time, more and more small businesses are unable to provide health insurance for their employees.

The first panel member to speak was **Billy Knorpp**. He explained that he worked for thirty years at Hewlett Packard and after he retired, he purchased RVP Business Systems, which sells and services point of sale systems, cash registers and credit card processing. He said it is a mid-tech company with 16 employees. His business has doubled in size in the last two years. The company does not create a lot of technology, but they sell and service it. As a result, his employees must be technologically-savvy. To get qualified employees, **Mr. Knorpp** said he has to compete with companies such as Hewlett Packard for technicians and salespeople who are comparable in skill levels. He also needs to be able to compete benefit-wise. This is very difficult because larger companies are able to offer much cheaper health insurance, usually with better benefits. This puts his company at a disadvantage.

Lou Aaron, chef and owner of Westside Drive-In, said that he has owned the Westside for eleven years. Before that, he worked for Hilton Corporation and for country clubs. He said that he is trying to compete with the larger chain restaurants in the area. In order to do this, he has to do things better than they do, including offering health insurance benefits. He said he considers his employees family. He has had one employee since 1986 and has very little turnover. In the restaurant industry, **Mr. Aaron** said health insurance is not offered very often. He said he has offered it since day one. Being able to offer his employees health insurance allows him to keep them. The number of employees at the Westside Drive-In varies from 15 to 30 depending upon the season, and about 30% of the employees take advantage of health insurance coverage.

Mr. Aaron said that last year he received a double digit increase in his health insurance costs for the third year in a row. In the past he has always covered 100% of the employees cost but, due to this increase, his employees are now paying 20% of the coverage. This is not a big deal to some, but to people like single mothers it is quite a blow. He said that small businesses need help in this area and that Association Health Plans are something he has considered as an option.

He said small businesses need tax incentives or tax breaks in order to help lower some of the cost of providing health insurance.

Rich Edvalson, owner of IntegriNet Solutions, said that his business supports the computer networks of 120 small businesses in Idaho. They have nine full-time employees and two part-time employees and have been in business for seven years. When they started, they paid the health insurance premiums for their employees and one-half of the premium for dependant coverage. **Mr. Edvalson** said that the problem has been that, as a small group, they affect their own renewal premiums each year so severely that the company can no longer pay any of the premiums for dependant coverage. They continue to pay for the employee but have gone to a very high deductible. As a result, **Mr. Edvalson** said a number of employees have declined coverage for their dependants and some employees get coverage through spouses that work for larger companies at lower rates. **Mr. Edvalson** said that there are obviously many drivers of the health insurance costs, but at their level there needs to be some way to pool the risk with a larger group. Otherwise, the increase in premiums will be unaffordable. He said his company had a 40% increase in premiums in one year.

Deborah Johnson, Asphalt Systems Company, LLC, joined the panel. She explained that her company is a paving company with 10-15 seasonal employees. Eighteen years ago when the company started, they had health insurance. Today, she and her husband alone have health insurance with a $10,000 deductible to be able to afford it. Their employee premiums range anywhere from $100 to $175 per month. She explained that company revenues are less than they were 18 years ago due to the fact that all costs keep going up. She noted that just this week two key employees left the company because they do not offer health care benefits. These employees went to a larger company for the same hourly wage but with health benefits.

Ms. Johnson agreed that small businesses need to be able to shop for health insurance at a fair price and not have to continually increase the amount that employees have to pay for coverage. She said that employees need to be aware of the cost of health insurance and be somewhat responsible, but not to the point that they cannot afford coverage.

In response to a question from **Representative Henbest, Ms. Schaefer** said she would try to get information relating to the percentage of small businesses that offer coverage. This information will include whether they only cover employees or if spouses are also covered. She said it has been difficult to get this information in the past. **Ms. Schaefer** said that the number of small businesses offering coverage in Idaho has decreased and Idaho is lower than the national average.

Representative Henbest said she has some information that said 32% of small business with fewer than 50 employees offer coverage, and that puts Idaho at the bottom of the nation ahead of only Arkansas and South Dakota. She said this is obviously a big problem in Idaho. **Representative Henbest** asked if different tax breaks are offered to small businesses as opposed to large businesses for offering health insurance. **Mr. Knorpp** said the cost can be deducted as a business expense, but that is the only one he is aware of.

Representative Block asked if the Access Card is something these businesses could offer their employees. She also asked if insurance pooling is something they would be interested in pursuing.

Mr. Knorpp said there is some pooling going on in Idaho but it does not appear to have been of much help to small businesses. This is offered by the Boise Chamber of Commerce but when he first examined it, it did not seem to be better than what he was already offering. **Mr. Knorpp** stated that pooling across state boundaries so that small businesses can join together and be able to negotiate in the same way the large corporations such as Hewlett Packard does would be helpful. These large corporations, according to **Mr. Knorpp**, are able to negotiate prices in very large blocks.

Senator Cameron asked what these businesses were doing to control insurance costs. **Mr. Edvalson** said his business has increased their deductible to $1,000 for individual coverage. He added that the policies are not as rich as they were a few years ago in terms of co-pays and deductibles. **Mr. Knorpp** agreed, and said his company has increased the deductible to $2,000 for an individual policy. He said the co-pay has also gone up and coverage has gone down. He said that his company does offer incentives to employees through a type of medical savings account. The company puts money into an account for employees to use for health insurance. This money can be carried over from year to year and so it encourages them to spend it wisely. It encourages them to be more thoughtful and frugal about how they are spending the health care dollars.

Senator Cameron said that as everyone knows the premium paid by a business is a result of the claims the employees are incurring plus administration costs. He asked how easy it was for these businesses to get claims data in order to help them decide what their benefit package should look like. **Mr. Edvalson** said for his company it seems that the premiums are set by magic. At renewal time, a new number appears and it is always higher. **Mr. Knorpp** said he did not think that information was available. **Senator Cameron** said he wanted everyone to be aware of this but that federal law prohibits release of the individual data. In his opinion, while they cannot get individual data, businesses should be able to get data that is tied to the overall group. **Mr. Knorpp** said that would be very helpful.

Senator Cameron asked why pooling across state lines would help save money. In his opinion, Idaho's costs might be lower than other states and sharing might force them to go up. **Mr. Aaron** said that he had heard there would be a 20% to 30% reduction in costs by pooling with other states. He has not researched who would coordinate this or which pool Idaho would be in. He assumed that this would be monitored so that cherry-picking would not happen. He said that the National Restaurant Association is fully behind the pooling concept.

In response to a question from **Senator Compton** regarding the Access to Health Insurance plan, **Mr. Knorpp** said he was not aware of the plan. **Mr. Edvalson** said that he was aware of it but, in his opinion, it is not a good plan. As he understands the plan, it is for companies that do not currently contribute to the premium of any of their employees' health insurance and it is funded

with a tax on the premiums that the carriers collected. He said that since employers that currently offer insurance are paying the premium, in effect those already offering insurance, such as his company, they are subsequently funding the coverage being offered through the state. **Senator Compton** explained that the premium tax dollars comes from premiums on all types of insurance including mortgage insurance. The Idaho Legislature decided to put some of that money into a program to help employers and employees obtain health insurance. He said that one of his concerns with this program has been the lack of understanding and suggested that more information needs to be made available.

Senator Cameron explained that the state was already collecting the premium tax and spending it in other areas. The Legislature felt that instead of spending all of it somewhere else it would be appropriate to use some of it to encourage people to buy health insurance. **Mr. Edvalson** said that in his opinion, any plan that would take money, either directly or indirectly, from an employer that offers health insurance to help an employer that does not provide coverage is a redistribution of wealth that does not seem like a good idea to him. **Senator Cameron** added that once these new employers offer the Access to Health Insurance plan, they also are required to pay premiums that are part of the premium tax.

Ms. Johnson said she was aware of the plan but the limitation on income is so low that the person has to be at the poverty level to qualify. She said her employees make over the limit but still struggle to get affordable coverage.

Senator Stegner commented that he appreciated **Mr. Edvalson's** comments but wanted to clarify that the premium tax is a tax on all insurance companies that do business in Idaho. Insurance companies are not charged income tax and this is a way for them to contribute to the state effort. Most states do this the same way. A premium tax turns out to be a volume tax rather than a net income tax. He said that, from time to time, special taxes such as this are dedicated to specific funds. The premium tax is actually dedicated to a number of different funds. The Legislature has chosen to take some of that premium tax and direct it to the effort of helping people get health insurance coverage. **Senator Stegner** noted that **Mr. Edvalson's** concern is one that all legislators have. As they struggle with finding a way for the state to help reduce the cost of health insurance, there is always the concern of offering incentives for businesses to get out of paying for it themselves. In his opinion, if people are not insured, they will get care in emergency rooms and the cost ends up being passed down to others or they become indigent and that is paid through property taxes.

Representative Collins asked what employers are required to do to be able to offer the Access to Health Insurance program to their employees. **Senator Cameron** explained that the employer must drop coverage due to it being too expensive and reapply for coverage under this program and have their employees qualify. Every employee in a company does not have to qualify, but the plan only covers those that do meet the requirements. To change this would require CMS to change the requirement, or the state could use Title 19 Medicaid funds that offer a 70%-30% match, not the 80%-20% match Title 21 offers.

In response to a question from **Senator Cameron, Mr. Knorpp** said none of his employees would qualify because their income is too high. His salaries range from $12.00 an hour to about $60,000 per year. **Mr. Aaron** said his employees' salaries range from $7.50 to $13.00. **Mr. Edvalson** said his computer technicians earn a base of $40,000 plus incentives and part-time employees earn about $11.00 per hour. **Ms. Johnson** said her employees start at $8.50 an hour and the highest paid is about $14.00 per hour.

Ms. Schaefer introduced **Kali Carringer**, owner of Moons Kitchen, to speak to the Task Force. **Ms. Carringer** said Moons has fourteen employees that are mostly part-time. She said they do not have the ability to offer any health insurance to any of their employees. She noted that she is paid $200 per month by her previous employer to find her own health insurance. Currently she pays $635 to cover her husband and herself under a COBRA policy. She has been trying to find insurance for herself and her husband for eight months. She said that unless she is working for a large corporation, she is basically uninsurable even though she has only missed work twice in the last five years.

Mr. Knorpp commented that if small businesses were able to pool, they would not get hit so hard when one employee has a catastrophic illness. He had an employee with such an illness that would have almost doubled their premiums. Pooling allows small businesses more room for negotiation.

Representative Henbest added that the amount small businesses pay for hospital costs of their employees is probably higher than a large corporation because small businesses do not get a negotiated rate. **Representative Henbest** asked if these businesses offer wellness incentives to their employees. She also asked what these businesses are paying for health insurance and what are they getting as far as benefits.

Mr. Knorpp said that wellness is a good idea but in a small business it does not have a large impact. **Ms. Johnson** said that her company has encouraged employees to quit smoking by paying them to get the patch. She said they had four employees who were successful and they received $500 from the company. She said her company will also pay for employees to get flu shots.

Senator Kelly suggested getting information for the next meeting from insurance companies and drug companies on what steps they might be taking to help small businesses control costs.

Senator Goedde said that Kootenai County has developed a self insurance program. He said the county emphasizes to employees that the health care plan is part of their total compensation package and any money that is saved in providing health care can be returned to employees through greater salaries. They have also encouraged employees to review their medical bills and have found many errors. **Senator Goedde** suggested having the insurance carriers discuss the differences between the costs and premiums for large companies and small companies at a future meeting.

Senator Cameron said that in a meeting with the carriers, due to huge increases in the individual market, it was found that the large group market was actually subsidizing the individual and small group market.

Senator Compton said that at an IACI conference on health care a pharmacist for Regence BlueShield discussed generic versus brand name drugs. He said that if everyone insisted on generic drugs, the price increase is not nearly as high as perceived. This pharmacist said that many times the newest drug is not very much different from the generic drug. **Senator Compton** asked if these small businesses' health insurance plans required the use of generic drugs or whether employees are given a choice. **Mr. Knorpp** said his employees pay less if they choose generics but they do have a choice. **Mr. Aaron and Mr. Edvalson** said their plans were the same.

Senator Compton said that a major issue in the cost of health care is that it is broken in the case of who pays for it, who provides it and who uses it. In his opinion, the end-user needs to be made more aware of the actual cost of care.

Ms. Schaefer noted that 98% of the firms in the country of 100 employees or more provide insurance, while only 49% of small employers with fewer than 100 employees provide insurance for employees. Sixty percent of the uninsured in the country work and many of them work for small businesses. She added that the administrative costs of health insurance is significantly different for small businesses compared to large businesses. She added that Idaho has done a good job in controlling mandates dealing with health insurance. She said the NFIB would welcome the opportunity to discuss small business health plans even though that is more of a national issue. NFIB also supports a movement towards a more individualized system of health care with options such as health savings accounts.

David Rogers, Administrator of the Division of Medicaid, was the next speaker. His presentation gave a general overview of Medicaid health care issues and will be available as an attachment to these minutes at: www.legislature.idaho.gov. **Mr. Rogers** gave the objectives of his presentation as follows:

, Frame the issue of rising health care costs
, Discuss the underlying dynamics of health care cost inflation
  - HIV/AIDS Case Study
, Review the unique challenges for Medicaid
, Spur thought on some potential solutions

Mr. Rogers quoted the Comptroller General of the United States, David Walker, "If there's one thing that can bankrupt the country, its health care. Its out of control." **Mr. Rogers** added that this quote is about our health care system in general, not just Medicaid. He said that in tracking health care premium costs, they are rising much higher and more quickly than any major economic indicator. The question is why. He stated that the dynamics include access, utilization and pricing. These are considered the variables that drive up the overall health care expenditures.

, Access: more people are receiving services
, Utilization: people are receiving more services
, Pricing: services cost more (inflation)

Mr. Rogers used the following HIV/AIDS case study as an illustration because t is so dramatic with respect to these variables.

HIV/AIDS Case Study

- Access: more people treated for HIV: First Cases Reported in 1981. Today, nearly 1 million people are living with HIV.
- Utilization: HIV patients using more drugs. No initial treatment in the early 1980s. Today's standard is three or more drugs.
- Pricing: Costs are higher for newer drugs. Oldest drug class (NRTIs) cost $300-450/month. Newest drug class (Fis) cost more than $2,000 per month.

This chart shows a hypothetical illustration of how access, utilization and pricing work together to have a compounding effect on health care costs using the HIV/AIDS Case Study.

Access	Utilization	Pricing	Total Costs
100,000	2 drugs	$200	$40,000,000
200,000	3 drugs	$400	$240,000,000
100% increase	50% increase	100% increase	600% increase

Mr. Rogers said that in dealing with Medicaid, they are trying to go back and figure out why those costs are rising and what can be done about it. This chart shows a snapshot of the number of people that receive Medicaid drug coverage under Idaho Medicaid. This is the number of people that actually receive the drug, not case load and not recovered by Medicaid.

	Access	Utilization	Pricing	Total Costs
SFY 2002	44,507	3.8	$57.70	$9,678,350
SFY 2005	52,351	4.5	$60.28	$14,105,450
Increase	17.6%	18.6%	4.5%	45.7%

Mr. Rogers said the above chart is an example that shows that Idaho Medicaid has done a good job controlling some costs by focusing on the price of drugs and encouraging the use of lower cost drugs and generics.

The next chart shows Medicaid community mental health expenditures through private providers. **Mr. Rogers** said they have not done as well in this area. This excludes inpatient expenditures.

	Access	Utilization	Pricing	Total Costs
SFY 2002	7,158	65.17	$25.36	$2,957,277
SFY 2005	13,483	68.29	$28.12	$6,470,640
Increase	88.4%	4.8%	10.9%	118.8%

The key driver of this increase, according to **Mr. Rogers,** was access. The number of people receiving services increased. **Mr. Rogers** said they broke this information down further and looked at mental health clinics. It also showed that access was the key driver in the increase in costs.

Mr. Rogers went on to discuss the Medicaid challenge.

- Medicaid is the nation's largest health care program providing comprehensive health and long-term care coverage for over 58 million people in the United States. (Medicare - 42 million).
- Medicaid is a federal program operated by the states.
- Medicaid spending in FY 2005 was projected to be $316 billion or more. $134 billion of that is state and local funds. Medicaid accounts for 43% of all federal funds to states.
- Medicaid provides comprehensive coverage for 28 million children (more than 1 in 4 of the nation's children) and some parents.

- Prenatal care and delivery for over 1.5 million births annually (37% of the U.S. total).
- Health and long term care coverage for almost 15 million seniors and persons with disabilities.

Mr. Rogers said the area of health and long-term care is an area where Medicaid takes a radical departure from the commercial and private market. Medicaid is really a safety net for health and long-term care for low- income elders and people with disabilities.

From a state perspective, **Mr. Rogers** said that national medicaid costs are rising and revenue has been a difficult issue for the states. It seems that Medicaid costs tend to rise at the same time state revenues tend to drop. In Idaho, general fund spending for Medicaid in 2005-2006 will be about 15% of the total general fund expenditures of the state. This has risen every year since 1987.

Mr. Rogers stated that Medicaid, as it exists right now, is not sustainable. The challenge is how to move forward. He added that Medicaid is a fairly significant lever within the overall marketplace. There is more than $1 billion dollars, mostly federal, in the health care economy today due to the Medicaid program.

Mr. Rogers said the 25% of the enrollees in Medicaid nationwide are elderly or disabled. This group accounts for about 70% of all Medicaid costs. Idaho's Medicaid population is slightly different. Sixty-seven percent of Idaho's case load is children and that is higher than the national percentage of 48%. In **Mr. Roger's** opinion, this is due to Idaho's coverage limitations and not having a medically needy program and the eligibility structure of our Medicaid program. He noted that Medicaid has historically been used to cover gaps in the federal Medicare program. Over 42% of all Medicaid spending has been directed toward individuals that are also covered by the federal Medicare program.

Mr. Rogers explained that the prescription drug funding should be moving out of the states as the Part D Drug coverage comes into effect. This will no longer show up as a Medicaid expense for the states on the federal books but the states are continuing to finance the cost. In his opinion, the states have become a long-term, ongoing source of financing for the federal program with no end in sight. One of the reasons so much money is spend covering those dually eligible for Medicare is because Medicaid is the primary payer of long-term care services in the nation.

Mr. Rogers said that because Medicaid is an income-based program and is very sensitive to economic conditions, it responds dramatically to changes in the insurance market. In 2000-2003, coverage changes for low-income families showed a decline of over 5% in employer-sponsored coverage for children. Medicaid coverage for that same time period increased 7.5%, picking up the slack and resulting in a slight decline in uninsured children within this population. For adults there was a decrease in employer-sponsored coverage of 4% and Medicaid coverage increased 1.2%. The amount of uninsured adults in low-income families actually increased 3.2%.

Mr. Rogers suggested the following as possible solutions and areas that deserve continued discussion.

- Public-Private Partnerships: The Access to Health Insurance is one of those areas that can be looked at as an example of this.

- Long-Term Care: A solution must be reached because Medicaid cannot afford to pay 50% of the long- term care costs in the nation. He said Idaho is doing a better job than most of the nation in moving away from institutional bias. Individuals who are receiving long-term care under Idaho Medicaid are generally moving toward less costly home community-based services. The key is to get ahead of the curve and address the needs before people are faced with the need for publicly financed long-term care services under Medicaid. As the population ages, more services will be needed.

- Evidence-Based Medicine: How do we make sure that the care being paid for is effective care? **Mr. Rogers** said that he has heard from people that we probably know a lot less than we should with regard to what is effective care. In his opinion, we probably know a lot less than we think we do.

- Information Technology: Most people agree that we have not done a good job as a nation bringing information technology into the health care marketplace compared to other sectors of the economy. There are many ways to do this.

- Health & Wellness: **Mr. Rogers** said that given the number of children in the Medicaid program, Medicaid is not a prevention, health and wellness oriented program. It is not designed that way. He said currently when people apply for Medicaid, the only requirement is income level. Health status is not really considered.

Senator Compton asked whether the three employees that JFAC approved for the Department for research and development have they been assigned. In other words, is anyone assigned to take responsibility for specific issues? **Mr. Rogers** said that it is not that clear at this time. They are bringing staff on board for research and development that will address many of these issues. One example is an aging resource center to try to find ways to promote non-Medicaid options for long-term care. He stated that it is a very broad topic and Medicaid is doing what they can to drive some of it. Medicaid operates in a much broader system and they must be aware of that. Anything they do impacts that system

Senator Compton commented that the federal government has been sending information out regarding the Part D- Drug Program stating that assistance is available to help people understand the program.

In response to another question from **Senator Compton** regarding low cost health clinics**, Mr. Rogers** said he would encourage the Task Force to continue to look into these clinics. Medicaid is beginning to work more closely with these clinics because they provide a lot of good quality care.

He added that at the federal level, there continues to be an effort to look to community health centers to address the uninsured population. In his opinion, these clinics are going to more a part of the landscape.

Senator Stegner asked who the 27% of adults are that are covered nationwide by Medicaid and where they are located. **Mr. Rogers** said these adults are low-income adults generally tied to low-income families. He noted that historically, Medicaid was tied to welfare or cash assistance but since welfare reform that has changed. There is still a very small number of low-income families that receive cash assistance under federal law and some that are receiving transitional assistance such as Medicaid. These adults are the remnants of the TAFI welfare program in Idaho. **Mr. Rogers** said this will include a broader population of those that are covered in the Access to Health Insurance or Access Card program. These people will continue to receive coverage.

Senator Stegner said that it would be accurate to think of Medicaid as something more than for just children, the elderly and the disabled. **Mr. Rogers** said that is vitally important. He said Medicaid struggles to break out of that mold of the historic welfare connection and to recognize that today the environment is much different.

Representative Henbest asked what percentage of the adults in the program are at poverty level and what is the eligibility criteria. **Mr. Rogers** said the eligibility is about 33% of the federal poverty level, contrasting to the Access card which is 185% of federal poverty level. Included in this coverage are minor groups such as refugee assistance, emergency services for non-citizens and very low-income adults.

Representative Block said she attended a conference in Washington, D.C. at which all the states were discussing the Medicaid budget because they all realize that it is increasing at a rate that cannot be sustained. The consensus was that everyone needs to work together to solve this. Long-term care was an extremely important area because it is an expense that is rising rapidly. She asked if there had been any discussion about more adequate insurance coverage for long-term care. **Senator Cameron** said there has not been a lot of discussion in that area and suggested having a panel discussion involving Medicaid and the private sector regarding long-term care. He said that long-term care has been an initiative of the Governor who has promoted a 50% tax break followed up with a 100% tax break. **Mr. Rogers** stated that this is another example of where to address the issue of Medicaid. Those low-income adult parents are not people who are going to be encouraged or incentivized to purchase long-term care insurance. The population for that is not on the radar screen of Medicaid.

Mr. Will Rainford, Insure Idaho Alliance, was the next speaker. His complete powerpoint presentation will be available as an attachment to these minutes at: www.legislature.idaho.gov. **Mr. Rainford** explained that he is a legislative advocate for the Catholic Diocese in Boise who belongs to Insure Idaho. Insure Idaho is a community alliance for affordable health care. His presentation discussed the Northwest Health Gap Study that depicts the current condition of medical care and insurance in Idaho.

Mr. Rainford stated that between high-wage earners who have comprehensive employer-based benefits, and the low-income people covered through public programs, lies a rapidly growing population with no coverage or inadequate coverage. These people fall into the health gap. The people falling into this gap include working families, small businesses and individuals. These are people who cannot afford health insurance but do not qualify for public benefits.

He said that, in his opinion, the chief concern confronting the Task Force is that the uninsured and the under-insured threaten to overwhelm the public health care system. In other words, when these people fall into the gap, they will have only public health care to turn to in crisis. At the same time, the economy of Idaho hangs precariously on the edge of this gap. Working families are one medical crisis away from falling into the abyss.

Mr. Rainford noted that as the quality of coverage declines, more people become under-insured Under-insurance is harder to capture statistically because it includes a number of factors:

- Limitations on services
- Increased cost-sharing (higher deductibles, coinsurance, and copayments)
- Reduced benefit packages

Under-insurance prevents people from getting the care they need and places people at financial risk.

Mr. Rainford said that the health gap is widening for the following reasons:

- Fewer employers are offering comprehensive coverage: Small businesses cannot be blamed for cutting back on the health care they offer to their employees. It is a rational choice in this economic market.

- Employers are shifting cost-sharing to employees: More people are working for small employers, which are less likely to provide coverage.

- Health insurance plans are charging higher premiums and cost-sharing: Declining employer-sponsored coverage contributes to the health gap.

- In 2000, 34% of people with income below 200% of the poverty level had employer-sponsored coverage. In 2003, 30% had employer-sponsored coverage. **Mr. Rainford** said that, from the data gathered, this will continue to decline over time.

- In 2000, 76% of people with income between 200 and 400% of poverty had employer-sponsored coverage. In 2003, 73% had employer sponsored coverage. Again, he said, there is every reason to expect that these numbers will continue to decline over time.

Mr. Rainford continued by stating that one-third of people working for employers who offer insurance are not covered either because they are not eligible or they cannot afford it. For the employees who are covered, employee contributions have increased 57% for single coverage and 49% for family coverage. In response to the statement made at the Task Force's last meeting that

Idaho is not feeling the pain of increased premiums because all states are experiencing increases in premiums, **Mr. Rainford** stated that while that might be true, Idahoans earns less than other employees in other states and small businesses in Idaho earn less than similar businesses in other states, causing us to feel the pain to a greater extent.

Mr. Rainford continued by stating that health insurance premium growth is outpacing growth in other indicators. Between 2003 and 2004:

- Premiums increased nine percentage points more than both economy-wide inflation and worker earnings
- Premiums increased faster than the estimated growth in medical claims expenses
- [U]nderwriting profits of insurers, defined as profits before investment income, grew substantially over the past year.

Mr. Rainford explained that from reading the health gap study and national depictions of the market, it would appear that the insurance industry is collecting premiums above and beyond what they estimate their costs to be each year.

According to **Mr. Rainford**, the individual market does not offer an escape from the health gap. The individual market is not affordable because individuals do not have spending power or buying power in the market that enables them to compete with large employer based pools.

Individual Health Insurance Premiums for Single Policies by Age, 1996 and 2002

Age	1996	2002
<40	$1,288	$1,661
40-54	$1,992	$2,767
55-64	$1,961	$3,703

Results from the Benchmark survey show:

- Overall enrollment in the individual market declined between 1999 and 2003 (98,561 compared to 85,860).
- In 2003, there were very few enrollees in the mid- and high-risk portion of the rate band for surveyed individual products:
  - 647 in the upper portion of the rate band
  - 2,738 in the middle section of the rate band
  - 75,969 in the lower portion of the rate band

  Mr. Rainford said this would show that the price of coverage in the higher risk bands is unattainable or unaffordable.

- The Benchmark Survey does not capture information related to the quality of coverage (whether enrollees are under insured)

Insurer practices contribute to the health gap by:

- Risk pooling: insurance is premised upon spreading costs among a large group
- Risk segmentation and risk avoidance ("cherry-picking"): risk segmentation refers to splitting the pool based on relative risk (such as health status or age), in order to avoid costs
- Insurers have incentives to avoid risk and compete around selecting "good risk," rather than around cost and quality of coverage
- Risk avoidance practices contribute to higher costs in the entire health care system

Mr. Rainford explained that someone is going to pay for the health care costs of high-risk people that are costly to insure. If someone with diabetes cannot get insurance, they still require health care and insulin to maintain their health. If that person is not insured, the public will pay for it one way or another. Methods health insurers often use to segment their markets that also contribute to the health gap:

- Deny coverage based on health status
- Use rating practices to price high-risk individuals out of the market
- Create different products or blocks of business that appeal to different classes of individuals based on their health status
- Charge customers more the longer they remain with a specific policy
- Close out blocks of business when the portion of "high-risk" people in them increases

Mr. Rainford said that traditionally those who fell into the health gap were low-wage earners, people of color and non-citizens. Today that health gap is widening and is capturing more and more moderate and middle-income people and small groups. He said that the Catholic Diocese stands before the Task Force for both of these reasons. The social injustice piece is compelling enough for them to make the effort to lobby for change. He said they are also very concerned about the community in general and the fact that working class and middle class families can go bankrupt with one medical crisis.

The financial consequences of the health gap are as follows:

- An estimated 55% of bankruptcies are precipitated by illness or medical debt
- 75% of those filing for bankruptcy due to illness had insurance coverage at the time they became sick
- More than half of those filing for bankruptcy due to illness were homeowners, and more than half had some level of college education
- The health gap forces small businesses to make very difficult decisions: keep coverage (with scaled-back benefits) at risk of going in the red, or drop coverage and risk losing qualified employees (as well as own financial security)

Mr. Rainford said that all of these threaten our economy in Idaho.

The health consequences of the health gap include:

- Problems getting medical care

- Barriers to receiving urgent care
- Health problems arising from postponing care
- Inability to afford prescription drugs or follow through with recommended treatment
- Hospitalization for avoidable health problems
- Poor general health
- Poor health can result in loss of productivity or inability to work at all

Mr. Rainford stated that a health care storm is brewing. Rather than get swept away in this tide, now is the time to look at the big picture and put all options on table for closing the health gap - in the short, medium and long term.

Mr. Rainford gave the following recommendations starting on the national level. He explained that the National Coalition on Health Care is a bipartisan coalition that includes almost one hundred of the nation's largest businesses, unions, health care providers, health insurers, and consumer groups. Members include: Qwest Communications, General Electric, Blue Shield of California, Kaiser Permanente, Safeway, and Pfizer. The coalition's first principle is health coverage for all. The coalition calls for systemic, system-wide reform. The National Coalition on Health Care website is: www.nchc.org.

Mr. Rainford said that states can:
- Exercise rigorous oversight over private health insurance markets to ensure transparency, accountability, and integrity
- Invest in public health coverage programs
- Ensure that large, profitable employers are making fair contributions toward health care

Mr. Rainford stated that, using WalMart as an example, when big businesses do not contribute fairly to health care coverage, it costs the rest of us a lot of money. Providing health care benefits on a fair basis is the way to solve the health care crisis for those working for large employers.

Mr. Rainford recommended that the Task Force act to:
- Convene public hearings across Idaho to gather input and gauge public support for different policies and approaches.
- Form a working subgroup to focus on critical issues of transparency in health insurance markets.
- Invite *Insure Idaho!* to prepare a more detailed presentation on pro-active solutions for an upcoming HCTF meeting.

Senator Cameron explained that at the last meeting there were a number of questions regarding how carriers come up with rates and how the rate band issue affected carriers. Due to those questions, the next item on the agenda is a panel discussion by Regence Blue Shield, Blue Cross and Primary Health. **Elwood Kleaver**, Primary Health, was introduced to go first.

Mr. Kleaver introduced **Steve Clay**, Primary Health's actuary and head of underwriting , to give the presentation. He has been with Primary Health for three years and was with Blue Cross and

several other carriers before that. He stated that he had been in health insurance on the actuarial side of the business since about 1991.

Mr. Clay went on to discuss the development of small employer rates. He said that Primary Health begins their rating process by looking at the historical claim costs for medical services. In other words, they look at what they are paying for a typical member per month and assess this historically.

Claims have two components: frequency and unit costs. Frequency includes services provided for every 1,000 members. For example, based upon 7,400 prescriptions per 1,000 members per year, if Primary Health pays an average of $32.00 per prescription, the Primary Health cost for the prescription is 7,400 x $32.00/12,000 = $19.73 per member per month. He said that Primary Health can do the same type of analysis for hospital inpatient cost, primary care physicians, specialists, hospital outpatient costs and zero in on the per member per month cost for each.

Mr. Clay said the it is important to look at inflation and remember that medical inflation is driving these costs up every year. He said the inflation does not necessarily just hit the unit cost component of claims. Inflation is also hitting the utilization or frequency component of claims. Unit cost is the cost per unit of service. Medical inflation is driving this up every year, based upon changing protocols (diagnostic testing, thresholds for prescribing medication) and new technology.

Mr. Clay said that from this information, Primary Health develops a typical cost per member per month or an average, and then looks at groups on a group-by-group basis. Initial costs are developed based upon a typical group demographic. Some groups have lower risk, some higher. Other costs are added to the premium rates that are connected with the providing of insurance. These include a small premium tax, commissions, administration and risk margins. Health insurance premiums differ from group to group, depending on the benefits they choose. Premiums in Idaho can also be adjusted up or down according to the risk of any group by plus or minus 50%.

Mr. Clay said that the regulations in Title 41, Chapter 47 of Idaho Code apply to both new and renewal business. It is important to understand the connection between new business and renewal rates. The carriers are limited on how new business is rated. The law allows increase in a group's renewal rate at renewal by an amount not more than the change in the new business rate plus 15% for changes in the rest of the group plus benefit design changes. The law defines the new business rate at that lowest rate a carrier has on the street, so increases can only be for the lowest street rate a carrier has plus 15%.

Mr. Clay gave an example of a group that is paying $2,000 per month for 12 months or $24,000 in premium and has a $50,000 claim. Under the law, the maximum renewal increase is the change in the new business rate plus 15% for risk. He noted that the 15% for risk does not come close to covering that $50,000 claim. Who ends up paying for that $50,000 claim? The answer, according to **Mr. Clay**, is all of the small groups that did not have serious claims that year. That is why all small groups see increases every year.

Lyn Darrington, Regence/Blue Shield, was the next presenter. She stated that her presentation

would include a history of insurance reform. In 1994, Idaho addressed small group and individual health insurance reform. The goal was to allow people for the first time to have guaranteed issue, meaning every one had the right to health insurance. Prior to that time, not all people were able to purchase health insurance and insurance carriers were able to turn people away. Guaranteed issue also put a limitation on preexisting conditions. This meant that if someone had a pre-existing condition, after a waiting period, coverage would be given for that condition. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). One of the primary goals of this was portability and guaranteed issue. This was similar to what Idaho and other states had already done. In 1996, Idaho passed the Managed Care Reform Act, which was one of the first significant reforms on how managed care was regulated in the state.

In late 1998-1999, it was noticed that enrollment in the individual market was dropping primarily due to cost. In late 1999-2000, the same thing began happening in the small group market. During that time, according to **Ms. Darrington,** this Task Force was meeting and needed to address affordability in order to stop people from dropping coverage and determine how to better spread the cost of paying for high-risk or sick individuals. The cost of the existing reinsurance mechanism at that time was being borne solely by the small group and individual health insurance markets. The Task Force needed to find out what people were paying for health insurance and where were the sick people as it related to the rates they were paying. The Task Force also needed to see how other states spread the cost of paying for sicker people and what the state's role was in that.

Ms. Darrington continued by stating that the findings were that the majority of people in the individual and small group market were healthy. This was one of the primary catalysts for expanding the rate bands. The Task Force found that there was not a good high-risk pool model that would suit Idaho and realized we needed to create our own model. The final finding was that there was not 100% deductibility of health insurance premiums for small businesses at that time. In 2000, the Idaho Legislature passed a reform package at the recommendation of this Task Force. This package included the following elements:

- Redefined mandated plans
- Expanded rate bands
- Created the high risk pool
- Provided a portion of premium tax to subsidize the high risk pool
- 100% state tax deductibility of premium
- Allowed single year age bands

Ms. Darrington explained that the single year rate bands were allowed because before, Idaho insurance companies were rating by age in five-year increments. This meant that when someone went from 49 to 50 years old or 59 to 60 years old, they experienced a big jump in rates. Single year rate bands make the increase more gradual.

Ms. Darrington said that today Idaho has some good market conditions with a healthy high risk pool for the individual market. She said it is probably one of the healthiest in the nation. Idaho has some of the fewest state benefit mandates. The 2000 reforms set out what they hoped to accomplish and that was to stop people from dropping out of coverage. Data from where the reforms took place

shows that in the individual market enrollment has increased.

Idaho's market challenges, according to **Ms. Darrington** include:

- Providing a better high risk mechanism for the small group market.
- The new business rate is still tied to the lowest rate a carrier offers.
- Privately insured people pay more for medical care in Idaho.
- Old products cannot be phased out in Idaho.

Nationally, Congress has been addressing the issue of Association Health Plans as discussed earlier. Legislation has also been introduced allowing insurance carriers to sell insurance in all fifty states in the nation, and it would allow individual purchasers of health insurance to take full advantage of every carrier's product options. **Ms. Darrington** said this is where benefit mandates come into play. Idaho is very attractive for carriers to domesticate in, because of the small number of mandates Idaho has, and then begin selling insurance in all fifty states. This will also involve dual regulation.

Dave Hutchins, Chief Actuary for Blue Cross of Idaho, was the next speaker. He said he has been with Blue Cross for three years and has over twenty years of experience in health insurance. He said that the difference between large group and small group is that small groups claim costs vary quite a lot from year to year. This is why the regulations allow only the 15% rate increase for renewals. Small groups cannot afford to have a 50% rate increase just because one member of the group has a catastrophic illness. With the regulations that are in place now, when that group gets a serious condition, their costs only go up 15%, at the most, above what a new business rate would be.

Mr. Hutchins continued by stating that for larger groups, because their costs are in a narrower band, the approval mechanism is different. The carriers generally decide what the largest claim amount would be that the group could afford and charge them the average cost of claims up to that amount. The larger the group is, the larger the claim they can afford. So the mechanism here is large claim pooling. For larger groups, in order to predict the future better, carriers often look at two years of claims experience. **Mr. Hutchins** said that models are being built that allow carriers to look at the health risk of a population. No matter who the large customer is, the better job the carriers do in predicting the claim costs, the better their rate is set for next and the happier they are. For small groups, because their claims costs could be three times as high in the next year, pooling is much more complicated.

Senator Goedde asked if there is a differentiation in the cost of administration and risk margining for large group versus small group. **Mr. Clay** said yes. He said it can vary from group to group. With the small employer group, the number of bills generated and eligibility work that needs to be done do make the cost to administer their business higher. He said that the claims side is not that much different. It is not unusual for carriers to have a percent or two higher administrative fee for small employer plans, but they have to take into account the competitive rates in the marketplace.

In response to another question from **Senator Goedde, Mr. Clay** explained that groups that present a lower risk profile might pay less than the pool amount but they may only have claims that are less than they pay. So in other words, this group actually supports the part of the group with higher

claims.

Mr. Clay, in response to a question from **Representative Black,** said he believes the law says no more than 15%. He added that just because a group might have a high claim, that does not mean that the carrier is going to rate for it at all. A large claim could be the result of a traffic accident in which the person was in and out of the hospital but is totally recovered. In this case, a carrier may still want to do business with that group. **Senator Cameron** clarified that the statute says 15% plus trend.

Representative Black said that it was his understanding that any carrier's entire group of clients is actually a pool and anytime one part of that group negotiates a lower rate, that is a form of rate-shifting. **Senator Cameron** asked the carriers if they do pool all of their products together or if they pool individual products, small group products and large group products in three separate pools. **Mr. Hutchins** said that Blue Cross rates the individual group on its own, small group on its own and each large group is rated on its own experience with the exception of the large claim pooling mechanism. He said there is no intent to subsidize between the lines of business and, for the most part, each line of business has been able to cover its own costs. To the extent that a very large group pays a lower administration fee, Blue Cross still tries to make sure a small group is better off having coverage than not having coverage.

In response to the same question, **Mr. Clay** said that Primary Health primarily covers only small groups with only a few large employers. He stated that they handle the groups similar to how Blue Cross explained. He added that any negotiation over premium rates generally tends to affect only the administrative costs. Primary Health would not gamble on the claims cost portion of the rate. All markets actuarially are expected to cover their own claim costs. **Ms. Darrington** said that Blue Shield also handles this in a similar manner to both of the above carriers.

In response to another question from **Representative Black, Mr. Hutchins** explained that there are many differences in rates besides administrative costs. He said these differences are in claim costs because of the different operation of the pooling mechanism. Small groups can only have a maximum of 15% increase, so the claim costs of a small group with a large claim will not be fully covered. The healthier small groups end up covering that. However, a small group cannot predict from year to year whether they will be the good group or the bad group. Large group claim costs are much easier to project and for these groups the administration costs are what is negotiable.

Representative Henbest asked how the lowest street rate is regulated. **Mr. Hutchins** said that a floor is set and then they project how much claim costs will be in the future and how much premium needs to be collected to cover those claims, administrative costs and premium tax. Then they figure out where the lowest rate can be set in order to keep as many groups as possible, so that overall each group will pay enough to cover all of the costs.

Representative Henbest asked about the regulatory requirement for figuring those costs and whether there is any reporting required of the carriers to the Department of Insurance. **Mr. Hutchins** said the carriers are required to file rates and if they are within the plus of minus 50%

range with no more than a 15% increase for renewals, they are in compliance. He said the market keeps carriers from coming out with a rate that is too low.

Representative Henbest referred to Association Health Plans and asked, given that small groups are essentially already pooled into one large group, what would be wrong with breaking the artificial state barriers by further enlarging the pool to lower costs. **Mr. Clay** said that in terms of allowing a national company to market in all states, local control at the state level provides some benefits to the citizens of that state. **Ms. Darrington** added that the proponents of these Association Health Plans such as NFIB and the U.S. Chamber of Commerce will say that the small employer market needs this in order to have the discretion to choose products anywhere in the nation where they can get a better deal. The opponents, who are primarily the health insurance industry and state departments of insurance, will say these plans are not such a great deal because there is no state oversight. This means that Idaho citizens in Association Health Plan plans have no state oversight over reserves, consumer protection or anything of that nature. The opponents will also say there is no federal requirement in this proposal that says these groups must be renewed for the next year, and that could mean that the unhealthier groups that are not renewed will end up back in the state plans. If these Association Health Plans do pass federally, the state and this Task Force need to be prepared to look at what this means for Idaho.

Representative Henbest said that since Idaho is a low regulation state, in her opinion and from information presented earlier, it would seem that most of the carriers offering the Assocation Health Plans would come to Idaho anyway. **Ms. Darrington** explained that the information presented earlier was not an Association Health Plan. What she presented earlier was a proposal that would allow carriers to sell in all 50 states without going through a state regulatory process to qualify to become an insurer in that state. **Senator Cameron** added that with Association Health Plans, there is no transparency whatsoever with regard to how the rates are set. In his opinion, this might actually allow "cherry-picking" in Idaho by allowing employers to get coverage with carriers that do not have reserve requirements, mandates on mammograms and the few other mandates Idaho does have, leaving only the unhealthy groups covered by state plans that have those requirements. **Representative Henbest** said that the argument could be made that Idaho does not have a totally transparent rating process today.

Representative Henbest asked if carriers instituted incentives for wellness programs for small groups. **Mr. Hutchins** said the carriers want very much to invest in these types of programs because every dollar that is saved in claims costs is one dollar lower that the pool of business has to be charged. He said that wellness programs are probably the fastest growing department at Blue Cross. **Representative Henbest** said that not all groups will participate to the same extent so the benefit is not as great. **Ms. Darrington** said that groups that jump from carrier to carrier are hard to track. If groups change carriers, it is hard to see if the wellness program was helpful or not. **Mr. Hutchins** said the carriers could voluntarily create products to encourage wellness.

Senator Goedde said that from comments made earlier that Idaho has few mandates, it was his assumption these comments referred to mandated benefits, not a lack of state administrative review of health plans. **Mr. Hutchins** said that was correct.

Senator Cameron said that there is a small group pool, a medium group pool and a large group pool. He asked for a definition of the medium group. **Mr. Hutchins** said that for Blue Cross, that includes any group with under 100 lives and is not in a small group. That can include groups of two or three because they work for an out-of-state corporation that does not qualify as a small group under Idaho law.

Senator Cameron asked if the carriers are pooling the rates for large groups which are 100 lives and more. **Mr. Hutchins** said the mechanism for pooling is only for large claims for large groups. For medium and small groups, there is more pooling because their claim costs are more unpredictable. **Mr. Clay** said Primary Health has a small number of medium and large groups and they handle pooling in a similar manner.

Senator Cameron said that it has been suggested that Idaho have a statewide pool that would cross carrier lines and maybe even cross between group size lines. He asked how that would work. **Ms. Darrington** said that in 1999, Regence presented information regarding what the percentage change would be if a carrier pooled everyone they insured into one pool. This information showed that the individual rate would increase 40%, small group would increase 14%, large group would decrease 11% and Medicare supplement plans would increase 10%. **Senator Cameron** said that it would be more like a community-rated concept. He was suggesting more of a pooling of large claims or pooling for high risk claims on other products besides the high risk pool. **Mr. Hutchins** said that to do this would require a good sliding size mechanism based on group size. Otherwise, it would still be a community pool.

Senator Cameron said the high risk pool has been a success for the carriers. He said he is not sure individuals are seeing that success because they are still receiving rate increases. He added that because of the high risk pool, the state is helping fund those catastrophic claims. He asked if something like this should be considered for the small group market. **Mr. Clay** said the opportunity to enroll entire small groups or members of a small group in the high risk program currently exists. He said that there is currently not a lot of enrollment. The reinsurance mechanism already allows a lot of pooling to take place in the small group market. He said that from a carrier standpoint, joining a statewide pool would require assurances that all carriers are following the same eligibility and underwriting standards so that one carrier does not pick up costs due to another carrier's bad habits.

Jonathan Bowman, Terry Reilly Medical Services, was the next speaker. His Powerpoint presentation will be available as an attachment to these minutes at: www.legislature.idaho.gov. He explained that community health clinics (CHC) provide medical care, dental care and behavioral health care. In his opinion, CHCs are part of the solution for the very difficult problems involving medical costs and coverage in Idaho.

Dr. Bowman explained that there are eight CHCs operating in 28 locations which saw 69,195 patients with 248,653 visits. In December 2004, two additional CHC organizations were funded. According to **Dr. Bowman**, CHCs are unique in that they:

- Provide comprehensive primary and preventive medical, mental health, and dental care
- Provide a superior model for chronic disease management and health improvement
- Incorporate health education, community outreach and support programs in the clinical practice
- Create formal and informal referral arrangements with community hospitals and other providers and specialists
- Collaborate with many other organizations when appropriate and available (*e.g.* hospitals, clinics, schools, Head Start, WIC, Public Health Districts and homeless shelters)

Dr. Bowman explained that the Terry Reilly Clinics serve the southwest part of Idaho. By federal rule, the Board of Directors is comprised of 50% users of the clinics and 50% people from the community. He said they offer discounted fees based upon income and family size. Forty percent of the staff is bilingual. Currently, the Terry Reilly Clinics are located in Boise, Homedale, Marsing, Nampa and Melba. He said there is a huge need for a clinic in Caldwell, but they have not been able to build one yet.

The services provided by the clinic include:

- Complete family medical care, including prenatal care. .**Dr. Bowman** stated that the Terry Reilly Clinics delivered 2% of all babies in Idaho last year.
- Diabetes specialty clinics using multidisciplinary teams.
- Participation in national chronic disease collaboratives for depression and diabetes. He stated the goal is to look at chronic disease using a national chronic care model that uses an integrated approach to care. This approach involves not only the doctor but the nurse, the pharmacist, the social worker and case manager as well as the patient.
- Laboratory, X-Ray, pharmacy and access to 340 B prescription drugs. **Dr Bowman** said that 340 B prescription drugs are the cheapest way to get medicine other than through veteran services. These are federally subsidized and the patients are charged at a much lower rate.

He stated that there is a huge need for dental services in the Medicaid population. CHCs are able to identify dental needs through the primary care arena, and because they offer dental care in the same building, they are able to treat them in a timely manner. Dental services are available in Boise, Homedale, Marsing, Melba and Nampa. They provide general dentistry, preventive services and emergency services.

Behavioral health services are also located in Boise, Homedale, Marsing, Melba and Nampa. The services include individual counseling for all ages, couples, and families, psychiatric services, mental health evaluations and Sexual Abuse Now Ended (SANE) Solutions To Physical and Sexual Abuse. **Dr. Bowman** explained that he sees many patients that have been hospitalized in acute psychiatric facilities for one or two days after trying to commit suicide and then they are released and told to follow up with a Terry Reilly Clinic because they cannot get care elsewhere. He added that part of the behavior health services the clinic provides is outreach. This includes clinics at women and homeless shelters in Boise and Nampa, case management, referrals and farmworker outreach They also hold clinics and events at three labor camps, community health fairs, classes, health parties, case management and referrals and provide community partnerships with hospitals,

clinics, private doctors and dentists and health departments.

Dr. Bowman said that of the people the clinic serves, 54% are white and 41% are Hispanic. Almost all of the people that visit the clinic are at 100% of the poverty level, 21% are between 100%, and 8% are over 200%. He said that when he started working there in the 1990s, 54% of the patients were uninsured. Since that time, it has risen to 62%. This has a huge effect on their budget because they get a set amount of subsidies from the federal government and still have to serve as many people as possible. He said in the last five or six years, the clientele has changed to low-income workers who cannot afford health insurance.

Following are the actual numbers of services provided by the clinic in 2004.

- 576 babies delivered
- 104,535 health care visits for 27,014 adults and children
- 12,540 dental visits for 6,151 persons
- 3,649 migrant or seasonal farmworkers served
- 2,925 homeless children or adults served
- SANE Solutions: 18,084 counseling sessions to 1,721 children and adults.

A breakdown of funding sources for the clinics is approximately as follows:

Patient revenues	41%
Federal funds	39%
Donated goods/services	15%
United Way	2%
Foundations/donations	1%
Other	1%

Dr. Bowman noted that some of the money comes from patient revenues. He said he likes this model because everybody is responsible for their bill. It is adjusted for income, but everyone is responsible to pay. He said that to help keep the Terry Reilly Health Clinics fiscally healthy in the future, state funding would be very helpful. There will probably never be a time when they do not need state funding. He stated that the clinic has had a building donated to them in Caldwell to serve 28% of the Nampa patients that live in Caldwell. There is still no community health center there because no funding assistance is available. If they were to proceed with this new clinic, they would have to do so with the existing budget, and already they are turning patients away from the Nampa clinic. Other forms of funding involve an endowment, individual donations, planned giving and in-kind donations.

Dr. Bowman explained that the clinics have extended hours including evenings, Saturdays and Sundays. This is important because it gives people a way to get care without going to hospital emergency rooms. He said that on Sundays, he has been told they get 30 calls a day on top of the 20 or so patients that come in for care. It is difficult to keep up with the demand.

Dr. Bowman continued by stating that evidence shows that the cost of treating CHC Medicaid

patients is 30-34% less than cost for those receiving care elsewhere; 26-40% lower for prescription costs; 35% lower for diabetics; 20% lower for asthmatics. CHC Medicaid patients are also 22% less likely to be hospitalized for potentially avoidable conditions than those obtaining care elsewhere, and are 11% less likely to be hospitalized for potentially avoidable conditions.

Dr. Bowman stated that President Bush said that he would like to put a community health center in every poor county. To build bridges to better care, policymakers can partner with the federal government, local communities, employers and families to invest in CHCs as models of fiscally prudent, high-quality, affordable health care delivery for all Idahoans. In closing, **Dr. Bowman** said that community health centers are making primary care affordable and accessible to all.

Senator Cameron asked if the clinics handle patients that are Medicaid-eligible. **Dr. Bowman** said they actually see a fair number of patients who are not Medicaid-eligible but who are very poor. He added that if any of the patients they see are Medicaid-eligible, they are given information regarding Medicaid programs available. He said that it is very difficult for people to come to the clinic because it is very busy and people do have to wait. He noted that Medicare patients are using the clinics to get pharmaceutical drugs because they cannot afford to get the medicine elsewhere.

Senator Cameron asked how **Dr. Bowman** viewed the role of community health centers in the overall health care delivery system. **Dr. Bowman** said it was difficult to say because, in his opinion, the entire health care system needs to be overhauled. He added that there will always be a population that needs to be served by community health centers. This is due to the fact that they are cost-effective and, in his opinion, there is part of the population that has difficulty fitting into a traditional model of health care. He also said that community health clinics allow the monitoring of the health care delivery product better than a private office.

In response to another question from **Senator Cameron, Dr. Bowman** said that the role of the CHCs will continue to expand to more than just assisting the poor. If the health centers can deliver a good product by seeing patients efficiently with high quality care, they should be able to provide care to more than just poor patients. He said that many patients go to the clinic rather than the emergency room because they want to be able to see their own doctor.

Mr. Kleaver said that he spent time going to community health centers throughout the country when they were having difficulties. He said **Dr. Bowman** is very modest when explaining what these clinics do. He said that he tries to promote the fact that when patients go to community health centers, they usually have no other place to go but they feel comfortable at the clinic and get good care. He stated that when people get good care when they are poor and/or unemployed, there is no reason they should not continue to go there when they get jobs and start earning more money. It is more than a safety net factor; it becomes a full-fledged practice. He said these clinics play a tremendous role and should be commended for what they do.

Bill Foxcroft added that the population these clinics see leans more towards the uninsured and Medicaid-eligible. Part of the reason the clinics struggle so much is because they do not have the payer base that a normal practice has. The federal subsidy is flat, and as the patient base continues

to grow, it is going to have to become more than just a clinic for poor, uninsured or Medicaid patients.

Senator Stegner said that he had toured the Nampa Terry Reilly Health Center and encouraged others to do so. He said it is very inspirational and that they do a wonderful job. He stated that, in his opinion, the free health clinic in Lewiston should consider the community health center model. **Senator Stegner** said it was his assumption that doctors who work in these clinic make less money and work longer hours than doctors in private practice. He said that for the state to expand the community health center model significantly, more health care professionals need to be willing to make such a sacrifice. He asked about the availability of such doctors, dentists and mental health professionals willing to do this.

Dr. Bowman said there are ten physicians at the clinic he works in. He said there are a lot of things that working in these clinics offers that do not exist in private practice. In the last ten years, he has seen that these clinics are actually more competitive in hiring physicians than in the past. In his opinion, part of the reason for that is because more physicians are wanting to go where they are needed. At a community health center, the medical care provided is more challenging and there is a much more cultural experience. He stated that there is a physician from the residency program that wants to join the clinic and there is no spot currently available.

Representative Block asked if the clinics use nurse practioners or physician assistants to provide care. **Dr. Bowman** said that one-half of the staff is nurse practioners or physician assistants and that is one way the costs are kept low. These people see a majority of patients and then they consult with the doctors when the cases are more complex. This is especially true in satellite clinics.

Senator Stegner was introduced to give a report on the Mental Health Subcommittee meeting. He apologized for the miscommunication regarding the date of the meeting. He explained that the members of the subcommittee are Representative Henbest, Representative Garrett, Senator Corder and himself. The meeting included a presentation from the Department of Health and Welfare giving the status and deficiencies of the mental health care system in Idaho. He said the subcommittee is trying to develop a list of priorities that are politically and financially reasonable for the Task Force and for the Legislature to consider in terms of modifying our mental health care delivery system. A number of things were identified for the subcommittee to get more information on and they identified some areas the Department of Health and Welfare feels are priority areas. **Senator Stegner** said that the subcommittee will present a report to the full Task Force at a later date for it to be reviewed in depth.

Representative Garrett informed the Task Force that the Department of Insurance, Health and Welfare and the Commission on Aging are making good efforts in figuring out how to handle the Medicare Part D program. She said that there is a steering committee in place that will be trying to develop a regional plan for outreach to help educate seniors on what they need to do. These outreach programs will probably begin sometime in October and November.

Senator Kelly asked what legislators should tell constituents regarding the Part D program.

Representative Garrett said that currently they are focusing on those that are dual-eligibles, and both Medicaid and Social Security should be able to help those people. The issue will become more difficult in October when other seniors start coming on board. Some Idaho-specific contacts will be made available as that date gets closer.

Representative Henbest said that she would like to have a presentation from the Department of Insurance at the next meeting regarding the regulation of how insurance rates are set and how transparent that is. She said she would also like information on how other states handle this. In her opinion, transparency is a critical issue.

Senator Goedde said that the Task Force has not had any presentations regarding worker's compensation. He said it might be beneficial to hear how that group handles medical costs for a different perspective.

Senator Cameron said that in the next few meetings it is planned to have some additional panels such as the small business panel that spoke today. From the discussion today there will be continued presentations regarding the Access Card issue, Medicare Part D and the mental health subcommittee. He said that a worker's compensation panel would be interesting, as would a panel on long-term care. He said he would also like to have the hospitals do a panel on their role and what their future role might be regarding health care. **Senator Cameron** said that he had asked IACI to provide a panel consisting of large businesses and how health care coverage affects them. He said to keep in mind their issues will be different from small businesses. He added that the Task Force may want to hear from the Employers Health Coalition and that the Gem Plan would like to give a formal presentation to them at a later meeting.

The next meeting was scheduled for September 22 in the JFAC room.

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