

Health Care Task Force Meeting September 22, 2005 Minutes

The meeting was called to order at 9:00 a.m. by Cochairman Representative Bill Deal. Other committee members present included: Cochairman Senator Dean Cameron, Senators Joe Stegner, Dick Compton, John Goedde, Tim Corder and Kate Kelly, and Representatives Max Black, Sharon Block, Gary Collins, Kathie Garrett and Margaret Henbest. Caralee Lambert was the staff member present from the Legislative Services Office.

Others present included: John Simmons, INL; Erwin Teuber, Jesus Blanco and Ed Baker, Idaho Primary Care Association; Woody Richards; John Watts; JoAn Condie, Idaho Pharmacy Association; Teresa Molitor, IACI; Joe Gallegos and Cathy McDougall, AARP; Corey Surber, St. Alphonsus; Molly Steckel, Idaho Medical Association; Linda LaMott, Idaho Association of Health Underwriters; Courtney Washburn, Idaho Women's Network; Leslyn Phelps; Brad Hoaglund, American Cancer Society; Representative Nicole LeFavour; Ted Roper, Department of Administration; Steve Millard and Bonnie Haines, Idaho Hospital Association; Steve Tobiason, IAHP/AARP; Suzanne Schaefer, National Federation of Independent Business; Shelli Stayner and Martin White, Mercer; Charles Hopkins, Nonpareil Foods; Scott Carrell, MPC Computers; Mary Lou Kinney, Covering Kids and Families; Kent Kunz, Governor's Office; Patti Campbell, Department of Health and Welfare; and Delmar Stone, National Association of Social Workers.

On a motion from Senator Compton and a second from Senator Corder, the minutes from the meeting of July 8, 2005, were approved unanimously by voice vote.

The first item on the agenda was a presentation from the Idaho Primary Care Association (IPCA). **Mr. John Watts** explained that there are many responsibilities that community health centers in Idaho are trying to meet, including providing health care to Idahoans who have few financial means and to those Idahoans who do not have health care insurance. For the last few years, the IPCA has been creating a service system to address the growing issue of uninsured Idahoans and to provide primary and preventative care to these people to avoid more costly care later on.

Mr. Watts stated that in the year 2000, a concept was brought to the Idaho Legislature by the IPCA that needed more work. The proposal has been revised and is now an effort to create a primary grant program where funds would be placed into the community health care system to provide services to low-income Idahoans or those without insurance. The IPCA also took a look at integrating a service system within the rural health care access grant program to create an ongoing primary and preventative care service within that program. After discussing this in

detail with legislators, industry representatives and insurance providers, it became clear that there was a need to create a pivotal role for the community health centers within the larger service delivery system of Idaho. This also involved creating a private sector partnership to provide care to uninsured Idahoans and to help them get into a type of maintenance program to prevent them from having more catastrophic medical expenses down the road.

Mr. Watts introduced **Mr. Erwin Teuber**, Executive Director of Terry Reilly Health Services. **Mr. Teuber** said that Terry Reilly Health Services is the first and largest of the community health centers in Idaho. Terry Reilly Health Services has been in existence since 1971 and provides basic primary medical care services on a sliding fee basis to five communities: Nampa, Boise, Homedale, Marsing and Melba. The health centers also provide dental services in four communities and mental health services. The goal is to serve low-income uninsured people. According to **Mr. Teuber**, Terry Reilly Health Services has among the highest quality providers available and uses mid-level providers as well as physicians, nurse practitioners and PAs.

Mr. Teuber stated that health care costs are high and continue to grow. Virtually everyone has had personal experiences with these increased costs. For example, two years ago Terry Reilly Health Services got notification of a 50% increase in insurance premiums for health care for its 180 employees. Like other employers, small and large, adjustments were necessary. At that time, the deductible was \$750 for employees; the increase forced it up to \$1,500. This was a difficult choice and there are some entry-level employees who do not have coverage because they cannot afford the deductible. Most employers have had a double-digit increase over the past few years.

Mr. Teuber state that the United States is currently spending 15.6% of its gross domestic product on health care. On a per capita basis, the nation is spending over \$6,400 per individual. There are 243,000 uninsured Idahoans. This figure does not address underinsured Idahoans. Some people are getting by with very high deductibles and limited coverage. Employers, both large and small, feel that they cannot continue to bear the ever-increasing financial burden and still compete. According to **Mr. Teuber**, large employers are able to negotiate better rates for insurance coverage, while individuals generally pay the highest rates. He views health insurance as type of second mortgage that American families are taking upon themselves.

Mr. Teuber said the goal of community health centers is to create a medical home. Currently, there are ten community health centers in Idaho scattered across the state in 34 communities. Collectively, these health centers serve over 25% of all the uninsured Idaho adults in the 19-64 year age group and are the medical home for 61% of the uninsured who are living at the poverty level. Community health centers strive to offer a welcoming environment for all the patients; this includes delivering services bilingually. Forty-six percent of the Terry Reilly Health Clinic staff are bilingual, signage is bilingual and bilingual outreach is done to reach families.

Mr. Teuber continued by stating that while the core service is primary care, combining that with preventive services is seen as the most cost-effective approach to keeping families healthy. In his opinion, this has something to do with the heritage of community health centers as recipients of federal funding which came through the U.S. Public Health Service. **Mr. Teuber** noted that the

Terry Reilly Health Services hours are convenient, with normal business hours as well as evenings and weekends depending upon the health center.

Mr. Teuber explained that there has been a major investment at the health centers in managing chronic diseases such as diabetes, depression, heart disease and asthma. Providers have been given specialized training as part of a national effort to zero in on cost-effective management of those diseases. Continuity of care is also very important and is part of the medical home concept. The alternative to the clinics is often emergency room care. On average, a service that may cost \$50 at a community health center clinic would cost roughly \$500 in an emergency room. For too many people, the emergency room is the “the medical home.” But, according to **Mr. Teuber**, it is not really a medical home because the patients are not known, there are no records and there is no follow-up or continuity. Too often, people are going to the emergency rooms because they have avoided care; their conditions have worsened and they do not have any other options.

Mr. Teuber said that unfortunately for the hospitals, emergency room care is uncompensated care. The cycle of postponed care due to patients not having insurance generally involves going to the emergency room for the care late in the stage of the illness, receiving overwhelming bills, not being able to pay them, going to the county for assistance through the medical indigency program, and in serious cases having to tap into the catastrophic fund. Those kinds of situations are far too prevalent and the IPCA feels that they can be reduced.

Mr. Teuber discussed the proposal, which includes:

- < Creation of public/private partnerships between the state, community health centers, safety net providers and working uninsured adults
- < Investment in a primary care account for basic medical needs and services
- < Assistance in helping individuals purchase low cost, high-deductible insurance

Mr. Teuber explained that the proposal starts at 150% of the federal poverty level (FPL), which is the level of the initial CHIP expansion, or 185% of the FPL, which is currently the eligibility level for the Access Card and the Small Business Model. The priority is to cover as many uninsured adults as possible, working in partnership with the Legislature to establish an appropriate funding stream and funding level. Based on current 2005 poverty level guidelines, a family of four at or below 185% FPL could make up to \$35,797 annually; at or below 150% FPL, that family could make up to \$29,025 and the adults could still be eligible for the program. The proposal would also create a 1115 Medicaid waiver that would allow premium assistance for a high-deductible insurance plan and contribution toward the purchase of primary care services at community health centers and other safety net providers.

Mr. Teuber stated that under the proposal, the qualified adult individual would purchase a high-deductible insurance plan with up to a \$75 per month state subsidy, with the qualified adult individual contributing any amount above this based on the plan purchased. The state and the qualified adult individual would each contribute \$25 per month towards a Primary Care Account (PCA). Qualified individuals would contribute to the cost of primary and preventive health care

visits by paying a per visit amount determined by income and the posted sliding fee schedule of the safety net provider. The Medicaid 1115 waiver would cover primary care services provided by primary care physicians and also primary care services including lab work, radiology, durable medical equipment, pharmacy, dental care, vision screening and mental health services.

CONTRIBUTIONS

	State Contributions	Individual Contributions
High Deductible Insurance Plan	\$75 monthly	\$0*
Primary Care Account	\$25 monthly	\$25 monthly
Monthly Totals	\$100 monthly	\$25 monthly plus co-pays**
Fixed Yearly Total	\$1,200 yearly	\$300 yearly

* Any premium amounts over \$75 is the responsibility of the qualified individual.

**The qualified individual pays applicable copayments after the sliding fee is applied.

Mr. Teuber explained that based on a Blue Cross BlueCare Basic PP0 3000 major medical plan, males and females aged 19 to 55 years could purchase a high deductible “Major Medical” health insurance product for less than one hundred dollars (\$100) per month. A qualified married couple could cover a significant portion of the premium. Under the proposal, family coverage is not considered because children may be eligible for the Medicaid/CHIP/Access Card program.

Mr. Teuber said that the primary care account, managed by the state or a private vendor, would be used by the individual to receive primary care through a specific safety net provider system, defined as tier one and tier two providers. The Primary Care Account would build at a rate of \$50 per month (\$25 from the state, \$25 from the individual). The qualified individual would have a maximum total of \$600 to pay for primary care throughout the year, like a flexible spending account (dollars could be expended if needed prior to their actual deposit into the account.)

The Network Provider System involves two tiers. Tier one providers are Community Health Centers and other safety net providers which operate with a sliding fee schedule available to patients with incomes at or under 200% of the FPL. Tier one providers, where available, are the first access points for qualified individuals. Tier two providers are safety net providers (*i.e.* primary care clinics run by Critical Access Hospitals and rural hospitals) available in areas where no tier one providers are located or where tier one providers are at capacity. Qualified individuals will be assigned to either a tier one or tier two provider through the Medicaid Healthy Connections assignment process. The individual will contribute to the cost of the primary health care visit by paying a per visit amount based on income and the sliding fee schedule of the tier one provider or a nominal copayment established by the tier two provider.

Mr. Teuber said that the proposal would work as follows.

1. The qualified adult individual visits a first or second tier provider. The provider charges \$100 for the visit. The individual who visits a tier one provider pays the published sliding fee rate he qualifies for at the time of the visit.

2. The first or second tier provider bills the insurance company for \$100. The claim is denied because the deductible has not yet been met. The \$100 claim is credited toward the qualified individual's annual deductible.

3. The first or second tier provider and the state or private vendor receives notice from the insurance carrier that the claim has been denied and the reason for denial.

4. The state or private vendor reviews the denied claim and account balance of the qualified individual's Primary Care Account.

* The balance in the Primary Care Account in this example is \$200. The entire health care visit bill, minus paid copayment, qualifies for reimbursement. The state or private vendor sends payment to the provider and notifies the individual of the new balance.

5. The first or second tier provider receives payment for the primary care office visit, minus the published fee, paid by the qualified individual at the time of the primary care visit.

Mr. Teuber continued by stating that as this is a Medicaid 1115 waiver, the state funding contribution would be matched at a 70/30 federal matching rate. There are at least three potential state funding sources identified for consideration:

1. Transfer a portion of the State Catastrophic Fund to offset future savings
2. Transfer a portion of funds from the health insurance premium tax
3. Find revenue from the state General Fund.

This 1115 waiver concept would provide employees of small businesses whose employers do not offer health insurance an opportunity to purchase a high-deductible health insurance plan. The plan would cover unexpected and expensive catastrophic illnesses. Community Health Centers and other safety net providers would provide the essential preventive and primary care services through a state subsidy and employee contributions into a Primary Care Account. This employee-driven concept is based upon the assumption that small business employers do not have the profit margins to contribute toward an employee's monthly health insurance premiums.

Mr. Teuber added that the proposal is a work in progress and there are many unanswered questions. Those questions include:

- < What role should small employers play?
- < Will very low-income adults be able to afford the contribution and copay and, if not, could these fees be waived or reduced in such cases?
- < How will unexpended PCA balances be handled?

< Should the state pool individuals to lower the cost of high-deductible insurance?

In **Mr. Teuber's** opinion, the proposal outlines the basic elements of a model that would promote access to care at the appropriate levels of care as well as timely care and preventive services. It involves the uninsured in paying for their care and spending wisely. It builds on an existing safety net of providers that utilizes private insurers and current administrative mechanisms to operate the program and does not further burden employers. It is a partnership involving the uninsured, the state and safety net providers. **Mr. Teuber** concluded by stating that the proposal still has policy questions and the IPCA looks forward to working with the Task Force and the Legislature in addressing these. A copy of the proposal is available in the Legislative Services Office.

Senator Cameron clarified the proposal is not something he or **Representative Deal**, as cochairmen of the Task Force, have endorsed and there are a number of questions that need to be addressed. He added that one of the things he has come to appreciate is that the community health centers have an important role to play in delivering health care coverage to uninsured or underinsured Idahoans. He said that the centers may be an underappreciated and underused tool for the state in taking care of the underinsured and uninsured. He asked, assuming general fund dollars or funds that the state has control over were used, how to get around the philosophical argument of individuals paying taxes for a benefit or program when there is no health facility located within a reasonable distance to them, *i.e.* how can the state ask people to use their tax dollars to help somebody who is fortunate enough to live close to a community health center.

Mr. Teuber answered that in the proposal there are two tiers of providers because there are parts of the state that do not have reasonable access to community health centers. In those parts, there are potential tier two providers; the only requirement is a nominal fee at the point of service with the remainder to be charged to the primary care account. It does not exclude any providers.

Senator Cameron asked whether an individual would be able to access a local hospital and local physicians, adding that the goal would be to hold down the costs and steer people toward the centers. Under the proposal, there may not be a savings if open participation is allowed.

Mr. Teuber answered that the savings would be derived from delivering the care at the primary care delivery level. The assignment of those providers to the enrolled population would be done much like the healthy connections program where there is a designated primary care provider for every healthy connections Medicaid patient. The state would determine whether there is reasonable access to a community health center clinic for that patient. In those cases where there is either not one available geographically, or if that provider is so overloaded they cannot accept more patients, the assignment would go to a tier two provider.

Senator Cameron said that any proposal that encourages a person to be personally responsible and to purchase coverage merits some discussion. He stated that he liked the primary care account portion of the proposal but noted that it comes with many questions, including:

< Who holds the account on the health savings account?

- < How do they access the account?
- < Do they access it on the first dollar benefits of those types of issues?

Mr. Teuber answered that the administrator of the account would probably be the state or a private vendor or some combination yet to be determined. It would not be the community health centers. He said that his understanding of the “first dollar” concept would be that the first dollar would be the sliding fee portion of the charge that is paid by the patient at the point of service. The remainder would then be billed to the holder of the primary care account.

Senator Compton asked for more information about the Medicaid waiver and what kind of dialogue the association has had with the Department of Health and Welfare. **Mr. Teuber** said that to his knowledge, there has not been much dialogue with the Department. They have been trying to refine the general concept and there is still a lot of work to be done in terms of touching base with other organizations.

Senator Compton said that since the target group is the uninsured and underinsured, and usually these are lower-income people, he is concerned about the \$3,000 deductible. He asked if this group is going to have to pay the first \$3,000 before they get any help and, if so, how they are going to be able to afford that. **Mr. Teuber** said he shared that concern and in his opinion, that is one weakness of the proposal. He said that the vast majority of these people are not going to come to the point where that is called into question. It is playing the odds. He said that their patients average three visits per year; if that is the case for the target population, the \$600 in the primary care account would easily cover that and some additional services for dental or mental health care. If it turns out that they have serious conditions that warrant seeing specialists and going to the hospital, there is that gap.

Senator Compton said he was a county commissioner for six years and was not even aware there was a clinic in the neighborhood. He said that county commissioners are involved with the indigent fund constantly and these clinics are where indigent people are sent for care. Since becoming a senator, he has been more involved with the clinics and is convinced that this is an area that needs to be pursued more thoroughly to figure out how to get people to use these low-cost providers instead of emergency rooms.

In response to a question from **Representative Black**, **Mr. Teuber** answered that the clinics are operating at near capacity but it depends on how that is defined. The clinics are pushed to capacity and in many cases people are turned away. But in some cases the facilities and equipment are available; they just need reimbursement in order to be able to add the necessary personnel. The growth potential is there. **Mr. Teuber** continued by stating that he thought the main saving grace is that there is some cushion now in capacity without having to expand facilities and equipment. Once expansion of facilities and equipment becomes necessary, he said they would draw on every conceivable source of funding available. Currently, they receive funding from the United Way and city governments in the form of community development block grant dollars. The Nampa facility for behavioral health was expanded with the assistance of community development block dollars through the city of Nampa. He said they access funds

from private foundations, corporations and individuals and have good credit to borrow money.

Representative Black said that while it is probably true that the state would like to eliminate all of the emergency visits possible due to the high cost of care, there is a reality that these hospitals depend on that emergency room income. He questioned whether hospitals support elimination of their emergency room facilities. **Mr. Teuber** answered by saying that when the question is asked in that way, the answer is clearly no. He does not think it is a question of eliminating or even dramatically reducing the volume of service that is provided in emergency rooms. It is a question of reducing the amount of non-emergency care that is provided at the hospital. For hospitals to provide this type of care in emergency rooms is not cost-effective.

Mr. Teuber explained that through the healthy community access program grant, the family medicine residency program, Terry Reilly Health Services, Garden City Community Clinic, the local hospitals and the United Way are all party to a study that was done at BSU and authored by Dr. Ed Baker. The study reviewed emergency room use and revealed that there is a significant amount of non-emergent demand for services that could easily be handled in physicians' offices. The highest rate of occurrence was between 3:00 p.m. and 11:00 p.m. In **Mr. Teuber's** opinion, this shows that there are people who could choose to go to primary care settings.

Representative Block said she attended two national conferences that focused on efficiencies in state Medicaid budgets. The states cannot sustain their Medicaid budgets and many states are implementing health savings accounts using health clinics, public private partnerships for the uninsured, and insurance pools much like this proposal. There is a lot of pressure being put on the federal government right now to allow the states more flexibility. She asked if there has been any research regarding what other states are doing and what has been successful. **Mr. Teuber** said that through the staff at the IPCA, there has been some research. They have learned that at least half of the states are contributing toward some type of program involving community health centers. There are some other private insurance models available as well.

Representative Henbest said she has questions about this program encouraging small businesses to no longer offer insurance and how such a program would change that marketplace. She asked what kind of uptake might be expected and what the overall costs would be. **Mr. Teuber** said that has not yet been researched. He noted that there are already many employees who do not have coverage and the number is increasing daily. This is the targeted group.

Representative Garrett said that the proposal left the small employer out. When the Task Force heard from small businesses, it was apparent that many want to provide insurance but cannot do so due to cost. She asked why the proposal left small businesses out of the partnership and if it could be made reasonable for them to contribute. **Mr. Teuber** said the proposal is still wide open; the rationale was that because of the statistics about how the small employers cannot afford coverage, the proposal may not proceed if they were included.

Representative Deal said that in hearing the questions asked by the Task Force members, the issue will probably receive more dialogue and exploration in the future.

Representative Deal introduced **Teresa Molitor**, Idaho Association of Commerce and Industry (IACI). **Ms. Molitor** said IACI held a conference this summer focusing on health care costs for businesses and as a result of that she was invited to bring some business people to talk to the Task Force about some ways they are dealing with the rising costs. She first introduced **Shelli Stayner** from Mercer to present some health care trends.

Ms. Stayner explained that Mercer Health and Benefits is a benefits consulting business that represents employers in the state and works with those employers to understand and manage costs. She said that in Idaho, large employers would be defined as having 100 employees or more. She explained that Mercer has been conducting surveys to determine what the large employer population is doing in the marketplace in order to help them make better choices. She noted that health care costs in general are going up substantially; there has been a minor slide this last year but an overall increase of 7.5% in health care costs. All employers are also juggling issues like HIPAA, privacy and Medicare Part D, all of which increase costs. **Ms. Stayner** explained that prescription drug costs are still averaging 14-15% on an annualized basis. The consumer-driven advertising is working well but it is very costly.

Ms. Stayner continued by stating that in Idaho, small and large group insurance has seen 20-25% increases. The increase in the employee cost share is eroding wages. Employers want to pay additional dollars in wages, retain employees and track new employees, but the health care and benefit costs are having a negative effect. She explained that trend is 13.7% in Idaho; this is the amount health care costs go up on an annualized basis and includes general inflation, drugs, devices, rising provider expenses, government mandates, consumer demand, litigation and risk management. Employers in the state are actually paying a lot less (about ½ as much) in contributions than the typical employer. This helps to bring new employers into the state.

The next agenda item was a panel of large employers to discuss how rising health care costs have affected their businesses and how they have responded to the cost increases.

Mr. Charles Hopkins from Nonpareil in Blackfoot, Idaho, was the first panel member to speak. He said that Nonpareil is one of the largest potato packers in the country and employs over 600 people. For the last 5-7 years, the company has experienced over a 10% increase in health care costs. The company is self-funded so it knows directly where that money is and what it is doing. On September 1 of this year, the company changed to a third-party administrator, meaning a group that basically handles the company's claims. **Mr. Hopkins** stated that the company has also changed its relationship with the provider community in Blackfoot, which is composed of a doctors' clinic, a hospital, and several independent doctors. The company's plan is set up so that a hospital provides all of the care necessary for the company's employees. If an employee wants to save the most money, he or she can they utilize the hospital. If, as in many cases, the employee does not want to go to the hospital or to the particular doctors provided by the hospital, the employee may go to a standard network doctor of their choice at a higher cost to them.

Mr. Hopkins said that Nonpareil has tried to attack the three areas of costs that exist in any business regarding health care. One is to control the administration of the health care costs by

moving to a third-party administrator. This option is somewhat less expensive and also provides individualized data to help the company determine how best to assist employees in getting quality, cost-effective care. The company also makes arrangements with local providers. Finally, the employee has been made responsible for some of the cost of their own care. The employee now receives more information on the actual costs and can find ways to save on those costs.

Mr. Hopkins said that he has learned that with the way health care costs are rising, in the year 2012, benefit costs and health care costs will exceed wages. He said Nonpareil is close to that now, since employees make \$7.55 - \$7.60 an hour on the average. Health care costs are very hard for the employees to cover and the company does all it can to pay benefits.

Representative Block asked if it would be helpful if there were some type of insurance pool that small and large employers could be part of to keep the expenses down. **Mr. Hopkins** answered by saying that there are many suggestions along that line in attempting to find a way to group all of the risks together in one spot, but Nonpareil would rather be in control of its own situation because it has some control of the data and the costs.

Representative Henbest said that in spite of all the money Americans spend on health care, we are not necessarily a healthier population than other industrialized nations. She was intrigued by what **Mr. Hopkins** discussed in terms of transparency and the consumer having a sense of what health care is costing them and what kind of service they are getting. She asked if there is anything that the state can do to help employers bring more transparency into the marketplace.

Mr. Hopkins said that perhaps the best thing the state could do in terms of transparency of information is give information on providers so that employers can determine if indeed they are getting the best deal. In his opinion, health care does not work as a free market system; there are too many factors involved. He added that if transparency was able to provide information on the best place to go for affordable services, employees would be better able to find out how they can afford health care. He said that in his program, he tells the employee where to go to save the most money; with more information, an employee could make that decision on his own.

In response to another question from **Representative Henbest** regarding lifestyle changes and healthy living, **Mr. Hopkins** said he would love to do more. The company's main office has a gym in the basement that any employee on health insurance can utilize when they are off-shift. The company provides a \$500 benefit for anybody who gets a physical, and the company provides flu shots every winter. In addition, an employee can ask for a blood pressure check and receive one right at the office. In **Mr. Hopkins'** opinion, one of the best things the state can do is to encourage good health habits; that means an effort to explain to people that if you eat too much or smoke, you are going to increase your health care costs.

Senator Goedde asked what happens to an employee who gets sick outside of the Blackfoot area. **Mr. Hopkins** answered that the company has set up a three tier program. If the employee is in Blackfoot, local providers are utilized. If the employee chooses, he or she can go to a standard provider in the area at a higher out-of-pocket cost. The third network is national and would serve

an employee if he or she was in Boise or somewhere out of the local or standard network.

Senator Compton asked what the company has done with regard to prescription drug costs. **Mr. Hopkins** said if it were up to him, name brand drugs would not be covered under the company insurance plan. Currently, the company charges employees a 15% copay of the cost of a generic drug and a 25% copay for a brand name drug. The company has contracted with a pharmacy benefit manager that has excellent rates for drugs. He said one problem is that doctors automatically give out brand name drug samples before offering the generic version. His company asks these doctors to prescribe the drug that will save the employee the most money.

Senator Compton asked what Nonpareil is spending per employee. **Mr. Hopkins** said the company spends about \$2.5 million annually on 1,100 lives.

Mr. Scott Carrell, Benefits Manager for MPC Computers and chairman of the Employee Health Coalition of Idaho (EHCI), was the next speaker. He explained that MPC has an employee base of almost 1,000 employees, 85% of whom live primarily in Canyon County and are mostly hourly. In August, MPC took on new ownership, which has allowed it more freedom and flexibility. From a benefits perspective, it has put them in the position as a sole employer. MPC is responsible for its own coverage as opposed to being in a pool.

Mr. Carrell said that the current benefits package offered by MPC is self-funded and that the company likes to be in control of managing its own benefit costs. He said the company has individual benefit plans that allow MPC to manage the benefit costs as opposed to pooling a plan. The benefit plans offered have come into existence through input from employees, new hires and also exiting employees. Information they have received indicates that the premiums charged as well as the deductibles are both lower than other employers.

Mr. Carrell continued by giving a profile of the members in the EHCI, stating that these members include Idaho Power, Micron and Boise Cascade. The group meets monthly to gather information on current health care trends and what other groups nationally are doing. According to **Mr. Carrell**, both the EHCI and MPC realize that the health care dilemma cannot be solved alone. Over the last year and a half, they have made a conscious effort to meet with the Legislature, IACI and the IMA because a coalition will be better able to find solutions. **Mr. Carrell** said that the challenge employers are facing is that they cannot control the pricing of benefits, and that is why it is important to have all of the different groups working together.

Mr. Carrell explained that over the last four years, both at EHCI and MPC, their per member per year dollars have ranged between \$1,500 to \$6,500; that represents anywhere from 38% to 58%. Total medical costs range between 9% and 28%, with more trending around 20%. MPC's premiums have ranged from increasing employee costs from between 38% and 45% with the traditional indemnity plan and between 35% and 111% for the PPO plan. He said that even though a significant amount has been passed on to the employer, the percentage employees are asked to pay is about 20%. MPC has the ability to incorporate some risk management features such as increasing or decreasing stop-loss levels or implementing excess aggregate features.

Mr. Carrell noted that when insurance features are tied to minimizing costs as an employer, those end up taking on expensive administrative costs. In order to help MPC get through the expensive increases, they have also had to pass costs on to employees such as increasing deductibles and out-of-pocket maximums as well as increasing premiums. **Mr. Carrell** said that MPC and the EHCI companies are rolling out their benefits for 2006 to the executive management teams. He said it has not changed that much over the last four years. There has been a slight reduction in costs over the last two years, but it is still in the double digits. They have sought out different avenues toward consumerism; this means migrating benefit plans to that calls for more costs to be picked up by employees. It also pushes the employees to get more education so they can compare which medical plan providers offer them the best value.

Representative Henbest asked whether, if the state sponsored a website or clearinghouse with information related to average pharmaceutical costs and hospital costs as well as quality information about different providers, this would provide any benefit for the employers in terms of transparency. **Mr. Carrell** said it would be a great benefit and that it would require a lot of education for employees to understand what information is available and how to access it.

In response to a question from **Representative Garrett** regarding federal notification requirements for Medicare Part D, **Mr. Carrell** said MPC is in the notification process through e-mail, employee presentations and mailings. MPC also plans to include a notice in the annual employee enrollment package for 2006. The EHCI is planning to use the same approach.

Mr. John Simmons, Benefits Manager for the Idaho National Laboratory (INL), was the next speaker. He explained that INL has traditionally employed about 6,500 individuals. Today this number has been split with CH2M Hill and Washington Group International in a joint venture that handles cleanup and covers about 2,700 employees, with Bechtel covering approximately 3,700 employees. He said that the issues they face are different because they are not covered by the government nor by the private sector. Their benefit costs are chargeable to the U.S. Department of Energy (DOE). This means any change in benefits design has to be cleared through DOE counterparts. He said the benefits are good but even the DOE is cutting back.

Mr. Simmons explained that INL has a chance to create a world class nuclear laboratory. To do this, it needs to hire world-class nuclear engineers who are mid-career level. To attract these employees, INL needs to offer retiree health coverage, and the DOE is reluctant to approve that. The average age of an employee nationally is 38 years old; INL average age is 48 or 49.

Mr. Simmons said that Bureau of Labor statistics released last week show that 7.9% of payroll is going towards life, health and disability insurance. He said he did not have this information for his company because the actuaries are determining what their health insurance rates will be next year. He explained that INL is self-insured and picks up 80% of the cost of benefits. He said it is significantly higher than 7.9%. He noted that in 1980, employees did not have to pay anything for health coverage, and to add a spouse cost \$2.00 per month and full family coverage was \$5.00 per month. Today, that would cost about \$200 to \$220 for family coverage.

In response to **Representative Garrett's** question, **Mr. Simmons** said that the notification requirements for Medicare Part D are very cumbersome and administering those is costing money that could be spent providing benefits. In his opinion, there are agencies that already have the information necessary to send these notices to those who are eligible and it would make more sense for them to do that than to have employers send it to every single employee. He said this may cause small employers to decide that the program is not worth the effort involved.

Representative Block said that long-term care is one of the most expensive components of the Medicaid budget nationally and statewide. Nationwide, Medicaid pays for about 2/3 of the costs of long-term care. She asked if any of the companies offered long-term care in their benefit packages. She also asked for possible incentives that could be offered to employers to do this.

Mr. Simmons said INL currently offers long-term care insurance as an option to employees. It is not provided as a company-paid benefit, and it is very broad as to what an employee can choose. He said that he was surprised there is not more participation in this program. The fact that premiums for this type of care are not tax-deferred, in his opinion, hampers interest. **Mr. Carrell** answered that MPC does not currently offer long-term care insurance to employees. The company did so four years ago on a voluntary basis but the participation rate was very low. In his opinion, incentives for employers to offer this benefit would be a good idea. **Mr. Hopkins** answered that as employers are forced to increase the cost of health care to employees, long-term care will lose value because they are trying to afford current care. He said his company does not offer it and he has never been asked about it.

Senator Kelly said that since large employers in Idaho represent a large part of the consumer market for health care, collectively these employers could help drive better public policy for minimizing health care costs through transparency from insurance companies and marketing of products. **Mr. Simmons** commented that he is an ERISA lawyer and that there is a dynamic the Idaho Legislature could play in strengthening an association like the EHCI. He explained that ERISA preempts state law if a single employer provides benefits to its employees, so employers seek that ERISA preemption from state insurance regulation. In his opinion, Association Health Plans would allow employers of similar industry type to come together to offer a single plan that would be less expensive administratively and would also give them bargaining power with local care providers. He said to empower that type of negotiation and ability would be very helpful.

Ms. Patti Campbell, Department of Health and Welfare, was introduced to give an update of the the CHIP-B, Access Card and Access to Health Insurance Programs. A copy of the handout is available in the Legislative Services Office. **Ms. Campbell** recapped the major points of each program and explained that the statistics have not changed much since the last meeting. Most people still choose the Chip-B card with 2,029 enrollees; that is a 9 person increase. There are 113 people enrolled in the Access Card program, up 40 since the last meeting. She emphasized that the numbers are somewhat fluid and that people enter and leave the program all the time.

Ms. Campbell said that since the children's program opened last July, there have been 10,589 applications. She explained that even though there is a small number actually in the program, not

all of these other applicants have been denied. It means that they may have been in the program at one point and left due to changes in circumstances. **Ms. Campbell** continued by stating that through August, 2005, the year-to-date premiums collected through the Chip-B program were \$190,000. The average monthly expenditure for CHIP-B has been \$105.75, based upon an average of expenditures in the last six months.

Ms. Campbell explained that the Access to Health Insurance Plan is for adults who work for small business owners. She added that children can participate in this plan as well. To date, there are 40 participating employers; 35 elected not to participate. There are 189 individuals in the program; 64 children, 76 parents of Medicaid/CHIP, and 49 adults with no children. She stated that there have been 350 denials, with the primary reason being that the employer did not offer insurance or elected not to offer health insurance. **Ms. Campbell** noted that if a person actually qualifies for Title 19 mandatory coverage, they cannot be given a choice of this program.

Ms. Campbell said that a survey was conducted in late August of small business owners and insurance agents to gauge their experience with the Access to Health Insurance Program. This was an online survey sent by e-mail to people who have had some contact with the program. Thirty-five percent of those who received the survey had elected not to participate in the actual program; 23% were participating; 23% were still deciding. Twelve percent submitted applications and were waiting for an insurance agent to provide them with a quote. Another survey question asked why they were not considering participating in the program. Most indicated the reason for not participating was due to the premium costs being higher than initially expected. Many employers wanted to participate in the program but were already offering some type of health insurance to employees and, at this time, this program does not allow that. Small businesses who elected not to participate were asked to elaborate on what program changes would be needed for them to participate. The following summarizes these responses:

- < Allow small businesses who already offer employee health benefits to participate
- < Do not require that employers pay 50% of the spouse's insurance
- < Raise the income limits

Ms. Campbell said that insurance agents surveyed regarding why employers declined to participate in the program indicated the biggest reason was the inability to afford to pay 50% of the combined premium for the employee and their spouse. Insurance agents responded that 34% of the employers considering the plan said their employees could not afford to participate.

Ms. Campbell said that based upon feedback from the Task Force and the surveys, the next steps the Department will take will include:

- < Federal waiver request to allow insured individuals to qualify for premium assistance
- < Federal waiver request to allow Medicaid eligible individuals a choice of premium assistance
- < Rules written to remove asset test for CHIP-B and Access Card for children

< Education meetings scheduled for agents

Senator Stegner asked if there was any way to estimate what the demand for the Access to Health Insurance Program would be if it were not capped. **Ms. Campbell** said that as the rules are written, the demand is probably what is being seen today. If the above changes were allowed, in her opinion, the demand would be at least twice the cap amount. **Senator Stegner** asked for clarification regarding CHIP-B applicants. the program. He said it was his understanding that there is no cap on this program. **Ms. Campbell** said that was correct.

Senator Goedde said it was his understanding that anything over \$55 million in premium tax collection is used to fund these programs, with 25% for each. He asked where the premium tax collection is going. **Ms. Campbell** said she did not have that information. **Mr. Gary Smith**, Director of the Department of Insurance, stated that for the current fiscal year 2005, the amount of premium tax was \$3.3 million and 80% went to the Access Card program. **Senator Goedde** said his concern was that with the decrease in the tax, and if the premium tax collection goes down, there will not be enough money to fund these programs.

Representative Deal asked if premium tax collection went down. **Mr. Smith** explained that while the amount of increase in premium tax collection by the Department did go down, there was still an increase over the prior year. In the last year, the total premium tax was \$81 million; this was an increase of about 6.5% over the prior year. The year before that was about a 10% increase. This shows that there could be a trend where the premium tax collection is going down. He added that this is the first year of the reduced premium. The Department has done a projection using the combination of a smaller increase and reduced premium showing that collection would go down about \$567,000 for next year and then would level off.

Representative Henbest asked whether CMS will look favorably on the waivers and changes being suggested. **Ms. Campbell** answered that it is very unlikely that they will waive the insurance requirement using Title 21 money because it is in law. However, Title 19 money that has a lower match rate could be used and that is how they plan to approach the waiver.

Senator Compton asked for clarification of the decrease in premium tax collection and whether this is a problem. **Mr. Smith** answered that it is not yet a problem. He said they are just looking at trends at this point because it is the first year and they will not really know until next spring when they get the big collections. One thing known for sure is that the Legislature reduced the rate of premium tax and as they look at the trends of revenues for premium tax collected in general, that is seen as trending down. That combination will make an impact in the first year.

Senator Cameron pointed out that it was anticipated with the premium tax reduction that with 5% growth there would be a slight reduction in dollars received for this program. As part of the initial bill, there was a provision that would have leveled out both this program and the high risk pool to 25% above \$50 million. This would have held harmless, to the best extent possible, the CHIP-B Access Card Program. That proposal was removed by the House Revenue and Taxation Committee. There has been and will be more discussion about whether to reintroduce that

proposal if there is a fear it would be in jeopardy. He said that **Mr. Smith** has stated that the Department anticipates increases in premium taxes, just not at the same level they once were. The ending balancing for June 2005 is at \$1,190,000 in premium tax dollars, and this does not take into account the 80/20 match. Essentially, this means the state left \$10 million on the table that could have been used for children's health insurance from either the CHIP-B or the Access Card. **Senator Cameron** said it is anticipated that there would still be \$4 million in premium tax or \$20 million unused toward the Access Card or CHIP-B. In his opinion, there can still be slight rule modifications as to who is allowed access the program without getting into trouble. He said it is important to be cautious regarding how fast the program expands, but it can be done.

Senator Stegner said originally the needs of the high risk pool and the CHIP-B programs were both taken into account. Many financial calculations were done in an attempt to balance that. In his opinion the Legislature has properly anticipated the growth of the insurance industry and has reduced the percentage of increases only slightly. The decrease in premium tax is implemented over a six-year period and it does not appear to be close to jeopardizing either program. He said he agreed with **Senator Cameron** that the language directing those funds needs to be reviewed regularly because it is based upon a percentage over a fixed amount. In his opinion, this is not a good way to go into the future.

Mr. Randy May, Department of Health and Welfare, was introduced to give an update on Medicare Part D and its impact on Idaho and the Department of Health and Welfare. **Mr. May** stated that in 2003, Congress passed the Medicare Modernization Act, of which there were two parts. The first part provided a prescription drug card that began in January 2005. The next phase will expand that coverage and the full Medicare Prescription Drug Benefit will begin in January 2006. He gave the following background information regarding the Medicare Prescription Drug Benefit, or Medicare Part D.

- < Coverage begins January 1, 2006
- < Available for all individuals who are entitled to Medicare Part A and/or enrolled in Medicare Part B
- < Coverage provided through Prescription Drug Plans (PDPs)
- < 30 PDPs in Idaho; average monthly premium of \$32/mo
- < Cost sharing (copays and deductibles) is based on the plan and client income
- < 11 PDPs will be targeted to low- income subsidy clients
- < Effective January 1, 2006 — all dual-eligibles (those covered by both Medicare and Medicaid) will have their drug coverage shifted to Medicare
- < Medicaid will no longer pay for drug coverage for dual-eligibles (with minor exceptions)
- < Must cover at least two drugs in each drug class
- < Must cover "substantially all" drugs in six classes (anti-psychotics; anti-depressants; anti-convulsants; immunosuppressants; anti-retrovirals; anti-neoplastics)
- < Medicare excluded drugs include: Anorexia, weight loss/gain; fertility; cosmetics (to include hair growth); symptomatic relief of cough and colds; prescription vitamins and minerals; non-prescription drugs; barbituates; and benzodiazepines

Mr. May explained that the excluded drugs will be covered by Medicaid. He noted that the most controversial part of the excluded drugs are barbituates and benzodiazepines that are used to treat seizures, spasms and anxiety disorders. He said there is discussion at the federal level about moving those onto the Medicare Prescription Drug Benefit.

Mr. May said that according to CMS, there are 194,000 Medicare-eligible Idahoans who will be impacted by this plan. About 148,000 of those are above 150% of the FPL. There are 29,000 below 150% of the FPL and there is some concern with the 15% of those that are below 150% of the FPL that are not currently on Medicaid, because if they are eligible for the low-income Medicare subsidy, they also become eligible for Medicaid benefits which makes them dual-eligible. At that point the state starts picking up its share of those benefits. He said there are currently 17,000 dual-eligibles who will receive that low-income subsidy and are currently getting their drugs paid for through Medicaid. **Mr. May** said that of the 29,000 people who are below 150% of the FPL, the Department has projected that about 7,000 will actually make application for and access Medicaid benefits. This will have budget implications. **Mr. May** described what was being done in order to communicate with citizens regarding this program.

Representative Garrett explained that there are a number of groups that are getting the information out to citizens. There is a region-by-region approach building on-the-ground coalitions to help with outreach and client education. There is partnering with providers and coordinated communications as well as efforts to establish enrollment places close to clients.

Mr. May stated that November 15, 2005, is the date people can actually enroll in the Prescription Drug Plan, so they are looking to establish enrollment places where seniors live and where trained staff is available to help them get enrolled. Another concern is that many of these people have complex needs, so it is going to be more difficult to figure out which plan will best fit their needs. **Mr. May** listed other key dates in the program and said that the Social Security Administration sent letters to over 30,000 Idaho citizens telling them they may be eligible for prescription drug coverage and help paying their premiums; these letters were mailed in May and June of this year. Currently, all of that information is being processed and the notices of decision are being sent. In his opinion, as soon as those letters reach Department of Health and Welfare clients, the Department will begin to see an influx of people who want to find out more about the PDP benefit and to apply for Medicaid and/or food stamp benefits.

Mr. May continued by stating that the prescription drug plans were approved the prior week but the Department has not received details about what those individual plans look like. He explained that beginning on October 27, 2005, CMS will send letters to the dual-eligibles, automatically assigning them to one of the dedicated eleven PDPs. This becomes a default enrollment if they do nothing else; on December 31, 2005, they will be enrolled in the automatically assigned plan and their prescription drug benefits will go to that new plan. If they do not want this plan, on November 15 they can register and enroll in a different plan.

Mr. May described the impacts of the upcoming changes on the Department of Health and Welfare (Division of Welfare), which include an ongoing requirement to help Medicare-eligibles

with their prescription drug coverage, client education, PDP selection and enrollment. In addition, many of these applicants may be eligible for other programs including Medicaid and food stamps. The Department has asked the Governor to support 27 additional positions in the Welfare Division to cope with increased education, application, enrollment and caseload activities statewide.

Mr. May also detailed the impacts to the Medicaid Division. He explained that the Department believed that the expensive seniors are already on their plan. In other words, those in nursing homes or those who have complex medical conditions may already be on the Medicaid program. A copy of **Mr. May's** presentation is available in the Legislative Services Office.

In response to a question from **Senator Compton, Representative Garrett** said the Association of Idaho Counties and the county social service managers have been included as another source to be used to educate citizens.

Senator Compton asked if there are any numbers regarding how much money someone will save using the PDP. **Mr. May** said that is largely individualized and one of the tools available on the Internet will figure out whether it is a benefit for someone to get on the plan. **Representative Garrett** said that she has heard numbers close to \$1,200 a year of savings. She clarified that this is an insurance program and it operates like an insurance program. The concern is that if these people without creditable insurance do not enroll by May 15, 2006, the next opportunity to enroll is January 1, 2007, and by that time these people will have an 8% penalty on their premium for postponing the decision to take part in the program.

In response to another question from **Senator Compton** regarding the 27 additional employees that are being requested, **Mr. May** said they are still looking at whether they need to hire full-time or temporary employees.

Senator Compton asked if someone can leave the program once they have signed up. **Representative Garrett** said yes, but only dual-eligibles are allowed to switch plans once a month if they want to. The rest of the enrollees can switch once up to May 15, 2006, at which time they are locked in until the next open enrollment.

Representative Henbest asked if the fact the two states are challenging the legality of this program in requiring the states to fund something passed by Congress that is a federal program is gaining any ground among the National Governors' Association or other groups. **Mr. May** said interest seemed to have peaked in July but has cooled off given other national news.

Senator Kelly asked if the prescription drug plans that have been approved are put together by specific companies or by the federal government. She also asked how the marketing of these plans is going to fit into the other outreach plans. **Mr. May** explained that these plans are from private companies that were submitted through a request for proposal process. The government selected 30 bidders and the contracts were signed on September 15. He said he has not seen the details of those plans and he cannot predict what the marketing will be, but he assumes it will be

direct-to-consumer marketing on television and is concerned that it will be confusing for seniors.

Senator Cameron said that in regard to **Representative Garrett's** concern that employers are not aware of their notification requirements, he suggested that the major carriers may need to increase efforts to notify agents and employers. He said he has not seen anything from the major carriers in Idaho outlining what employers must do.

Mr. Ken Hurd, Department of Insurance, was introduced to discuss long-term care insurance. He explained that he was going to discuss the long-term care awareness program that the federal government started in 2003. This program was dormant until the Governor's program started in January 2005. At that time, Idaho was one of five states chosen as pilot programs. In Idaho, letters were sent to 125,000 people between the ages of 50 and 70 telling them where to get more information about long-term care. **Mr. Hurd** stated that once Medicaid Part D came along, the long-term care program went away; the emphasis on Part D took precedence. He said that at the end of March, each state filed a report regarding who had requested more information. He said it was about a 6% return. It was felt by CMS that many people were made aware of their options for long-term care through this program.

Mr. Hurd continued by stating that the five pilot states decided the federal initiative was not as successful as anticipated. As a result, Idaho put together a committee to look at group long-term care for state employees. Since that time, Aetna has been chosen and a bid should be finalized by the end of September. He said the tentative date for this to start is January 1, 2006. In his opinion, Idaho benefitted from this initiative more than some of the other states.

In response to a question from **Senator Compton**, **Mr. Hurd** said this will be a policy available to state employees through Aetna offering long-term care. It will also be available to spouses, adult children and parents. The employees will have to pay for this insurance themselves.

Mr. Hurd explained that the goal of the pilot program was basically to make people aware of long-term care. The federal government was trying to inform people of the fact that the government is not going to take care of everyone's long-term care and that they need to do something to take care of themselves. He said that options for this care included annuities, long-term care insurance, life insurance and reverse mortgages.

Senator Compton said that over the last few years there have been tax incentives offered for the cost of long-term care. He asked if there is any indication of how many people have taken advantage of that incentive. **Mr. Hurd** said it is a very small number. Unfortunately, long-term care insurance is very expensive and most people cannot afford it. It is hoped the number of participants will increase because of the ability to offer group coverage. He said that there is also a long-term care partnership program that was passed two years ago based upon the federal COBRA law that partners Medicaid, insurance companies and the Department of Insurance. This allows an individual to buy a specific long-term care policy and have some of their assets excused from Medicaid. This would take effect if the changes to the COBRA law are passed. It is still being debated in Congress.

Representative Henbest asked if there is a problem with the insurance companies dropping long-term care insurance after people have paid into them for some time. She asked if there are consumer complaints in general about the ease of using the long-term benefits. **Mr. Hurd** said that contracts that began about ten years ago guaranteed renewable contracts, so even if an insurance company withdraws from the market, they are still required to maintain that product unless it is sold to another insurance company. He said if company losses are high, companies can increase the premiums and that increases the lapses on these contracts. He said that is a concern for every state. **Mr. Hurd** stated that older long-term care contracts had gatekeepers on them that made it very difficult for people to collect. The newer contracts are not that difficult, but this is a new product and it will take time to make the process easier. He said the Department of Insurance can always look into any complaints people make regarding policies.

Representative Henbest asked if there is a need to create a stronger regulatory environment for these products. **Mr. Hurd** said the Department uses NAIC rules, which are standardized. Each state has the right to increase or add to that rule but states cannot lessen regulations under the rules. As long-term care insurance evolves, the Department will adjust these rules accordingly.

Senator Stegner gave a summary of the Mental Health Subcommittee meeting held on September 21. A copy of the meeting minutes are available in the Legislative Services Office.

Representative Block commented that as a former teacher, she knows that children's mental health is very important to the education community. She said children who have mental health issues are not able to learn to their full potential. She asked if the education community is being included in the subcommittee's discussions and deliberations. **Senator Stegner** said they have not been included, but only because the subcommittee has not done any kind of outreach. The subcommittee has been working closely with the Department of Health and Welfare and members of the mental health service community. He said the subcommittee would welcome additional input from educators and added that they have not been concentrating on children's mental health. **Representative Henbest** said that the subcommittee's meeting was concluded by requesting a future presentation on issues surrounding children's mental health, including the conflict between courts and the Department over financing children who have conduct disorders.

Senator Corder added that based upon the recommendations from the subcommittee and the numbers given by the Department today, it is pure speculation as to the success for any of these programs. The cost is going to be very high and in his opinion, they have their work cut out for them. He stated that prevention is very important because if prevention is successful, the other problems will be diminished. He also noted that some of the recommendations sound expensive but there are ways to incentivize private industry to help with those.

Senator Compton asked who is ultimately responsible for the mental health issue. **Senator Stegner** answered that Ken Deibert and his assistant, Ray Millar, at Department of Health and Welfare deal almost exclusively with mental health issues. **Representative Henbest** said that **Mr. Millar** gave a presentation to the subcommittee outlining who is responsible for what given the diagnostic category, status of insured versus uninsured, if they are Medicaid-qualified and by

age. She said this was the first time she understood why the state has significant gaps in its delivery system. The funding is categorical depending on diagnosis and income level. The services seem to follow what is paid for. She added that there is also the question of how much responsibility counties have and why the private sector does not play as large a role in this area as it does in other areas of health care. In her opinion, the system is fragmented and that makes it difficult to say who is in charge.

Representative Garrett said that Idaho does have a mental health authority housed in the facts division of Health and Welfare. They set policy and deliver some services. She said the major part of the state's mental health delivery system is Medicaid, and that has a lot of impact on how mental health services look in Idaho. The problem with that is that if someone is not Medicaid-eligible, where do they go for services? **Representative Garrett** added that the correctional system has become a de facto mental health care system. She said there is a mental health coalition building around the Department of Health and Welfare, Corrections and Vocation Rehabilitation trying to work on this problem of joint jurisdiction and concerns. She added that the Department of Family and Children's Services, where the mental health authority is housed, has asked for a transformation grant to look at the system as a whole. Part of the requirement of that grant is to have a cabinet-level committee that is underway.

In response to a question from **Senator Compton**, **Senator Stegner** said it is the hope of the subcommittee to develop a plan with the support of the Task Force. He said they will be presenting specific legislation for consideration by the Task Force for discussion and hopefully will move it forward to the germane committees of the Legislature.

Representative Deal explained that items to be discussed at the next meetings include how insurance companies create their rates, a report on the Gem Plan, and a report on the status of the high risk pool and mental health. **Senator Cameron** noted that if members have suggested discussion items in the past that have not been covered, they will still be covered. He said he would still like to have a panel discussion with the Idaho Hospital Association as well as any other health care related legislation.

Senator Cameron noted that there was initially a request that the Task Force look at worker's compensation issues and asked the members if that is direction in which they want to go. In his opinion, there might not be enough time to cover that topic during this interim. **Senator Corder** agreed that the plate is full without taking up worker's compensation issues at this time. **Representative Deal** agreed and said that in his opinion, worker's compensation is outside the scope of the Task Force at this time.

The meeting was adjourned at 2:45 p.m. The next meeting was scheduled for October 27.