To be approved by the Task Force

MINUTES
Health Care Task Force
9:00 a.m.
July 11, 2007
J.R. Williams Building, Basement Conference Room
Boise, Idaho

The meeting was called to order at 9:00 a.m. by Cochairman Senator Dean Cameron. Other members present included Cochairman Representative Gary Collins, Senator Joe Stegner, Senator John Goedde, Senator Patti Anne Lodge, Senator Tim Corder, Senator John McGee, Senator Elliot Werk, Representative Sharon Block, Representative Carlos Bilbao, Representative Jim Marriott, Representative Fred Wood, Representative John Rusche and Representative Margaret Henbest. Legislative Services staff present were Eric Milstead and Toni Hobbs.

Others present at the meeting were Devon O'Brien, Willamette Dental of Idaho; Director Bill Deal, Donna Daniels, Gina McBride, Joan Krousch and Shad Priest, Department of Insurance; Richard Cauchi, National Conference of State Legislatures; Christine Herrera, American Legislative Exchange Council; Tim Olson, Therese Bishop, Georganne Beyonin and Jim Pinkerton, Regence; Leslie Kelly-Hall, Corey Surber and Jeremy Pisca, Saint Alphonsus; Linda LaMott, Idaho Association of Health Underwriters; Steve Millard, Idaho Hospital Association; Bob Seehusen and Ken McClure, Idaho Medical Association; Pam Eaton, Idaho Retailers Association; Joe Gallegos, AARP; Norm Varin and Elwood Kleaver, Primary Health; Robyn Crosby, OSCI; Representative Nicole LeFavour, District 19; Tarin Magrini, Idaho Community Action Network; Darrald Bean, Bean Insurance; Erin Bennett, Veritas Advisors; Rakesh Mohan and Ned Parrish, Office of Performance Evaluations; Julie Taylor, Karen Early, Jack Myers and Mike Reilly, Blue Cross of Idaho; Mike Brassey, St. Luke's Regional Medical Center; Kathie Garrett; Scott Pugrud, Connolly and Smyser, Chtd.; Rick Thompson, Department of Administration; Julie Swanson, Legislative Services Budget and Policy Office; Steve Tobiason, Idaho Association of Health Practitioners; Lyn Darrington and Amy Holly Priest, Business Psychology Associates; and Paul Leary and Patti Campbell, Department of Health and Welfare.

After opening remarks from Cochairman Senator Cameron, Representative Collins moved that the minutes from the November 11, 2006 meeting be approved. Senator Stegner seconded and the motion passed unanimously by voice vote.

Richard Cauchi, Program Director for Health Programs for the National Conference of State Legislatures (NCSL) was introduced as the first speaker. His complete PowerPoint presentation is available at the Legislative Services Office.

Mr. Cauchi's presentation covered the topic of rising health insurance costs. He said that rising

costs and the idea of declining insurance coverage are often the duality of health issues in legislative settings. He said that traditionally these two issues are in conflict with one set of bills designed to address cost containment and another set of bills trying to expand coverage. **Mr. Cauchi** stated that in the last two to three years these two issues have been seen coming together. States are looking at the issues and coming up with more practical solutions. States are coming up with "mix and match" solutions that include cost containment and expanded coverage combined in the same legislation. These solutions include quality and wellness in the mix and states are realizing that a solution will take more than one year.

His presentation includes charts showing national expenditures for health services and supplies by category and the annual change in total health benefit costs. It also includes a chart showing that the sickest 10% of the population account for 64% of the expenses.

Mr. Cauchi noted that 156 million people (61%) are covered through employment based insurance with 14 million (5%) being covered under individual or non-group coverage.

He gave the following data on who pays health insurance premiums in the United States and in Idaho:

U.S.	Idaho
INDIVIDUAL	INDIVIDUAL:
Employee Contribution 18%	Employee Contribution 20%
Employer Contribution 82%	Employer Contribution 80%
FAMILY	FAMILY
Employee Contribution 24%	Employee Contribution 26%
Employer Contribution 76%	Employer Contribution 74%

Mr. Cauchi went on to explain Health Savings Accounts (HSAs). He said that HSAs:

- Allow for tax-free accumulation of savings
  - Tax free contribution; Tax free accumulation.
  - Tax free withdrawals for health care services, COBRA and Long-Term Care Ins. premiums, retiree health premiums for Medicare-eligible retirees
- Must have qualified "<u>High Deductible Health Plan</u>" (HDHP)
  - Self-only: Minimum $1,100 annual deductible, $5,500 Out-of-Pocket max
  - Family coverage: Minimum $2,200 deductible, $11,000 Out-of-Pocket max
- Contributions
  - Self-only: limited to level of deductible up to $2,850
  - Family: limited to level of deductible up to $5,650 max
- <u>Growing enrollment and use</u>; HDHP total premium about 16 to 20% lower (averages $640 below HMO for an individual; $1,700 for family)
  - Who pays high deductible, employer or individual, makes a big difference in the

economic appeal of HSAs

Mr. Cauchi said that there is growing enrollment and use of HSAs that is dramatic by percentage numbers. He noted that premiums for these high deductible plans tend to be about 16% to 20% lower than traditional policies. He said that who pays the high deductible for these plans makes a large practical difference. If the employer is paying it, the policies seem very appealing to employees; if the employee is mainly responsible for the deductible, they are not as popular.

He showed charts showing the number of uninsured in each state in the United States and a chart showing the number of non-elderly that are above the federal poverty level (FPL) that are uninsured. He said the second chart gives an idea of a part of the population that might be reached.

Mr. Cauchi went on to discuss the following state strategies being used to make health insurance more affordable while covering some of the uninsured. These strategies include:

- "Exchanges"/"connectors" and "section 125" plans
- Premium assistance
- Subsidize health insurance for the poorest people
- Reinsurance
- "Mandate-free" or "lite" insurance plans
- Limited benefit plans
- High risk pools
- Pooled insurance purchasing
- Premium caps

He explained that "connector/health insurance exchanges":

- Are a central part of the Massachusetts 2006 health reform.
- Are a concept to provide a single place for persons to purchase insurance coverage.
- Allow for greater transparency or competition and for pre-tax dollars to be used for the purchase of individual insurance coverage (section 125 plans).
- A number of states are now examining this in 2007:
  - CA, CT, MD, MI, MN, OR, and PA.
  - RI enacted a separate "cafeteria plan" requirement for all employers with 25 or more workers for pre-tax purchase of health insurance. No state or employer payments are required. (7/3/07)

He said that the Massachusetts plan requires all residents to purchase health insurance as of July 1, 2007 (extended to December 31) with some exceptions and has been criticized for developing this concept of the "individual mandate." He explained that this is an untried approach and it raised the question of affordability and enforcement. As of mid-June 2007, 135,000 previously uninsured persons have obtained free or subsidized coverage. Four state proposals in 2007 also include the "individual mandate" concept including CA, ME, OR and PA.

Mr. Cauchi said that Massachusetts (MA) and Vermont (VT) are implementing employer assessments to help finance reforms; MA requires $295 and VT requires $395 per uninsured employee annually. Maryland introduced in 2006 a law to impose a payroll tax for large employers not meeting a minimum requirement for employee health insurance that was struck down on the basis of ERISA. California, Illinois, Michigan and Pennsylvania are states considering 2007 proposals that would tax employers based on the health benefits offered to employees. Maryland, Minnesota and New Hampshire considered this idea but it did not pass in 2007.

Mr. Cauchi went on to say that Montana created the Small Business Health Care Authority Act. This act:

- Targets small businesses
- Creates a new purchasing pool, State Health Insurance Purchasing Pool, to obtain health insurance
- Subsidize pool insurance on a sliding scale basis
- Provides for tax credits to small businesses that are currently offering health insurance
- Is funded by a tobacco tax

Other states working on health insurance reform but with different plans include NY, WV, TN, NM, OK [June '07 law], AR and AZ. Visit http://www.ncsl.org/programs/health/business.htm for more information.

His PowerPoint presentation includes examples of what other states are considering in more detail.

In summary, **Mr. Cauchi** reiterated the following key themes regarding reform proposals.

- Premium affordability is a core feature or goal in most state activity this year
- Public-private partnerships are embraced by most states
- Role of and impact within small business
- "Political" successes are most common after all stakeholders are at the table; bipartisan endorsers are important to enact reform
- "Economic" successes can be measured in different ways - still too early to judge

Christine Herrera, Director of Health and Human Resources for the American Legislative Exchange Council (ALEC) was introduced to explain state efforts in addressing rising health insurance costs. She explained that ALEC has the largest nonpartisan membership association of state legislatures. Their mission is to promote the principles of free market, limited government and federalism. Her complete PowerPoint presentation is available from the Legislative Services Office. Her presentation outlined her perspective of what constituted "The Good, the Bad and the Ugly" of state health reform plans in Massachusetts, California, Wisconsin and Indiana.

Following is **Ms. Herrera's** presentation regarding the Massachusetts plan that she discussed in the most detail. Her complete PowerPoint covers the same information for the plans in

California, Wisconsin and Indiana.

Massachusetts Plan

Goals:

- Universal coverage, especially for Massachusetts' 460,000 uninsured residents.
- Elimination of the "free-rider problem,**"** where those with insurance subsidize those without insurance.
- Appropriate care in the appropriate setting - keeping people out of the ER and with their primary care doctors.
- Access to a wide range of affordable, portable, tax-free health insurance policies for individuals.
- Successful implementation of the plan . . . with no new taxes nor a "single-payer" financing system.

Ms. Herrera said that in her opinion the real goal of this plan was bipartisan support for a health policy idea.

The plan includes four components.

1. INDIVIDUAL MANDATES

- As of July 1, 2007, every Massachusetts resident is required to have health insurance—either through their employers, through Medicaid/Medicare, or by purchasing it on the individual market.
- Every Massachusetts taxpayer must indicate on his state income tax return that he, and his dependents, had health insurance during the previous year, with no lapse longer than 63 days.
- Failure to comply in 2007 results in the loss of the state income tax exemption—$220 for an individual, $440 for a family.
- Failure to comply in 2008 and beyond results in a penalty equal to 50% of the lowest-cost insurance policy available for each month without coverage.

2. SUBSIDIES AND MEDICAID EXPANSION

- Uninsured individuals with incomes under 100% federal poverty level (FPL) get fully-subsidized health insurance. They pay no premiums.
- Families with incomes up to 300% FPL—that's a family of four making $60,000—get sliding-scale subsidies for premiums.
- Massachusetts expanded Medicaid eligibility for children in working families with incomes up to 300% FPL. Massachusetts is undergoing aggressive efforts to sign up the 106,000 uninsured (almost 25% of its uninsured) who already qualify for Medicaid.
- Increased Medicaid spending will lead to a 50% match from the federal government. This "new money" will be used to, in part, fund the program.

3. THE "CONNECTOR"

- The Massachusetts Health Care Connector combines the individual and small group markets under a single set of regulations. This allows both groups to take advantage of

"economies of scale" (in administration and risk pooling) available to large businesses.

- Any individual can purchase coverage through the Connector with pre-tax dollars. The insurance is portable from job to job.
- Any business with fewer than 50 workers can choose the Connector as their insurance plan. Multiple employers can pay into the Connector on behalf of a single employee.
- Starting in 2009, Medicaid will designate the Connector as its "insurance plan."

4. EMPLOYER MANDATES

- Employers with more than 11 workers must pay a $295 "Fair Share" contribution if they do not make a contribution to their workers' health insurance that is "fair and reasonable."
- "Fair and Reasonable": An employer must offer a group plan and pay at least 1/3 of the cost, or an employer must offer a group plan and make any contribution as long as 25% of full-time workers are enrolled.
- Employers with more than 11 workers must also establish a Section 125 "cafeteria plan" so that their employees can pay their share of insurance premiums with pre-tax dollars. Businesses that do not comply face a "free rider surcharge" if the state pays more than $50,000 for care provided to that company's employees.

Ms. Herrera went on to discuss what she views as the good, bad and ugly of this plan.

The Good

- Preserving tax breaks:
  - The Connector extends generous federal tax breaks for employer-sponsored insurance to individuals.
- Establishing portability:
  - The Connector makes coverage easier to purchase and maintain for part-time and temporary workers.
- "Funding people, not providers":
  - Massachusetts is converting federal uncompensated care funds for hospitals into a premium assistance program for low-income individuals, administered by the Connector—a good alternative to wholesale Medicaid expansion.
- Addressing the "free-rider" issue . . . although uncompensated care amounts to only 3-5% of health care spending.
- Addressing the uninsured . . .although Massachusetts had the 8th lowest uninsured rate—and the number of uninsured dropped by 19% before the plan's implementation.

The Bad

1. INDIVIDUAL MANDATES

- Represents government intrusion at its finest. By virtue of living in Massachusetts, residents will be forced to purchase a government-defined product—whether they want it or not.
- Compliance is futile. Mandating health insurance is often compared to mandating car insurance. But states that mandate car insurance typically still have 15 percent of their

drivers uninsured—the same percentage as states that don't mandate car insurance.

- Impossible enforcement. Using state income tax filings for enforcement will make it hard to track down the low-income, the elderly, immigrants, the homeless, the mentally-ill, (and even some state legislators) who don't file state income tax returns.
- Weak penalties that are often cheaper than purchasing coverage.
- Red tape like guaranteed issue, modified community rating, and 43 mandated benefits keeps the market distorted and increases the price of the mandate for the young, healthy, and "rich" (incomes greater than $55,000, which are 35% of Massachusetts' uninsured).
- Forcing purchase of a government-defined benefits package will ratchet up spending. Special interests will lobby (and win) for inclusion in the "standard package"—thus increasing the price of coverage and subsidies to help keep up with the cost of care.
- Religious concerns. Current mandated benefits in Massachusetts include in vitro fertilization (IVF) and contraceptives—and future mandates could include other "religiously-objectionable" practices. Also, nontraditional "insurance," such as medical bill sharing in churches, was not deemed by Massachusetts as acceptable coverage.

2. SUBSIDIES AND MEDICAID EXPANSION

- Expansion of government welfare programs well into the middle class. All means-tested government programs tend to discourage work, family formation, and wealth accumulation.
- "Crowd out"—when the government begins to provide a service, it crowds out private-sector or charitable alternatives. For every 10 people that join a government-run health program, six of them leave the private market.

3. THE "CONNECTOR"

- Can have regulatory powers. Vague implementing language says that the Connector can determine which plans have "high quality and good value."
- "High Quality": Individuals below 300% FPL get a "Medicaid plus" plan; those above 300% FPL get capped deductibles and mandate-rich benefit packages.
- "Good Value": Was originally intended to mean monthly premiums of no more than $200/month, but regulation has ratcheted up monthly premium costs to $380. High premiums caused Massachusetts to exempt 20% of the low-income uninsured (who do not qualify for subsidies) from purchasing coverage. Those already in the small group market will also see their premiums rise 2-8%.
- Can become "single-seller" health insurance. When subsidies and tax advantages are available only through the Connector, it can squeeze out other market activity. Other "Connector" states have proposed mandating that residents drop existing coverage and enroll in one of the Connector's plans.
- Is the Connector like a benign "farmers market"? As intended, yes. But if the Connector flexes its regulatory muscle, the "farmers market" can devolve into one in which a regulatory body determines which farmers can participate in the market, which vegetables participating farmers can sell at predetermined prices, and which residents can receive subsidies to buy vegetables. The farmers market will become the sole place to buy vegetables in the state, thus eliminating Albertson's and Costco.

4. EMPLOYER MANDATES

- Compliance is futile. In 1974, Hawaii became the first state that required employers to provide health insurance for their workers. Over thirty years later, Hawaii's uninsured rate still hovers at 10%. Many Hawaiian employers escaped the mandate by shifting work to (exempt) part-time employees.
- Weak penalties—"pay," at $295/worker, is cheaper than "play."
- Cost-shifting from businesses to their workers. Businesses faced with "Fair Share" fees will absorb those costs with higher prices or by cutting workers' pay, benefits, or jobs.
- "Fair Share" runs afoul of ERISA and previous Court rulings that strike down state laws mandating specific health benefits. Avoiding an ERISA lawsuit means getting a Congressional exemption (see Hawaii).

Ms. Herrera highlighted Idaho's relatively high ranking in the *Index of Health Ownership*. She explained that the mission of the *Index of Health Ownership* is to enact positive, free-market health policy reform. States can improve "health ownership" in four key areas:

1: Free Market Medicaid Reform
2: Deregulated Health Insurance Market
3: Competition between Health Providers
4: Tort Reform

She said that Idaho ranked 29th in free market medicaid reform, 47th in competition between health providers, 19th in tort reform and 4th in deregulated health insurance market. **Ms. Herrera** said this #4 ranking means that when it comes to the private health insurance market—according to *The Index of Health Ownership*—Idaho is doing things right.

In summary, **Ms. Herrera** said there is no magic bullet that can fix health care. However, a big part of health policy is "preventive care"—that is, knowing what *not* to do. In her opinion steering clear of the "bad and ugly" portions of the Massachusetts, California, Wisconsin, and Indiana plans is a good place to start. She said that policymakers should keep in mind the Hippocratic Oath: "First, do no harm."

Senator Cameron announced that a preliminary report of the Health Care study this task force requested would be available tomorrow at 10:00 in the JLOC meeting.

Representative Henbest commented regarding Mr. Cauchi's presentation that, in her opinion, the 27% to 30% uninsured rates for nonelderly includes children so the rate could be higher than that. **Mr. Cauchi** agreed.

Representative Henbest asked whether Idaho is the top state in regard to crowd out risk. **Mr. Cauchi** said that he was not an expert in this area but would get the original material for the task force if they were interested. He said the general message of the slide is that crowd out can be a very real factor. **Senator Cameron** added that the overall message of the chart is that Idaho has a higher percentage of employers with employees at 250% of the poverty level. So if Idaho was

to expand Medicaid or SCHIP, that would have a larger potential for crowd out than some other states. **Mr. Cauchi** agreed and said that the chart is about the number of people in employer sponsored plans and that expansion of certain plans would have that risk. **Representative Henbest** clarified that it reflects wages that are earned in the state.

Representative Henbest said, in her opinion, the marketplace is already doing harm and asked how free market reform would do more harm when reform is trying to lessen the number of uninsured. **Ms. Herrera** said that transparency is a huge part of free market health policy reform. On the supply side, people do not actually know how much they pay hospitals and doctors. She said that in her opinion it is not market failure that has contributed to health insurance problems, it is government failure or over regulation. She thinks Idaho is doing things right with a number four ranking in the nation as having one of the best health insurance markets in the country. **Ms. Herrera** noted that Idaho also has a low number of mandates. Her idea of reform would be to make policies affordable without government involvement.

Mr. Cauchi agreed that there is a lack of transparency in much of the market. He said that a modest number of states have enacted laws encouraging transparency and it is beginning to be looked at. **Ms. Herrera** said the question is whether states should mandate or let the market take the lead. She noted that most hospitals do not necessarily want transparency.

Senator McGee commented that the hospitals in Idaho Falls and Caldwell are owned by Hospital Corporation of America and they are beginning to add information to their website to make the process more transparent.

Representative Rusche asked whether the "connector" or "exchange" is expected to lower the cost of marketing and distribution. **Mr. Cauchi** said it is expected to but insurance companies are being encouraged to do more systematic marketing of individual products.

Representative Rusche commented regarding a slide showing that larger companies that tend to have employees over longer periods of time have moved in the direction of care management activities. On the other hand, he said that small employers tend to focus in a different area so the cost of the disease shows up rather than the cost of managing the disease. **Mr. Cauchi** agreed and said that employers do not control the market or the details of the benefits package and that small employers especially are at a disadvantage. **Representative Rusche** asked, since a lot of population in Idaho is individual/small group, whether there are places that assist the carriers in price sensitive products and in taking a longer term look at health care. **Mr. Cauchi** said there is awareness of it but he does not think many programs or states actually look at that specifically.

Senator McGee asked **Ms. Herrera** whether there is any data showing how effective the state plans she discussed have been. **Ms. Herrera** said that the only state that has implemented its plan is Massachusetts and that state is adopting a wait and see attitude. She stated that the Massachusetts plan was a win for the Governor, but the way the plan was implemented left a lot of things undetermined. Reports should start coming in within the next year. She added that it remains to be seen whether the uninsured that do not qualify for Medicaid will sign up. **Mr.**

Cauchi added that there is also the question as to what will be considered successful as to the number of uninsured who do get coverage. He said there is a difference between political success and economic success.

Senator Stegner commented that the connector concept goes further than he had heard before in terms of setting up a single entity for insurance. He said the concept of combining individual and small group into one group has advantages because it creates one large group and helps spread risk. He asked whether that was part of the discussion in Massachusetts. **Mr. Cauchi** said that was an active goal. **Ms. Herrera** said the main reason for the connector is to make it easier for small businesses to offer coverage.

Senator Stegner commented upon the differences in the presentations and said they were both very helpful. He asked if **Ms. Herrera** was suggesting that there should be a higher penalty for noncompliance with the Massachusetts plan. She said no, a higher penalty would make it even worse. She added that the penalty was a compromise and said that for the plan to work, Massachusetts needs to realize that enforcement has major flaws and the penalties are not necessary. **Mr. Cauchi** said that Massachusetts had a two and one-half year task force on health reform that included a conference committee in December 2005 that met for five months. The Governor stepped in and came up with compromises that resulted in this plan.

Senator Cameron stated that the connector concept will be included in the report tomorrow. He said that he struggles with this idea because another layer of government does not necessarily solve anything. He noted that this Task Force tries to find ways to lower costs and find coverage for the uninsured and the two concepts sometimes work against one another.

Senator Cameron asked what other states are doing to address the free rider dilemma. **Mr. Cauchi** said that there are no stand alone solutions to that. **Ms. Herrera** said she sees the problem being addressed in Medicaid; putting larger copays for certain situations or for use of emergency room for nonemergency situations.

Senator Cameron asked whether other states are addressing premium assistance programs for children. He commented that Idaho still hears about premium costs and the uninsured but is still not seeing people take advantage of the access card plans and so on. **Mr. Cauchi** said he was not an SCHIP expert but he thinks SCHIP expansion and state support is a popular notion.

Representative Henbest said there is a difference between what small and large employers can offer and asked whether the connector concept would include care management strategies. **Mr. Cauchi** said yes but many are so anxious to offer a broad range and to keep all providers at the table there is not as much emphasis on managed care.

Representative Block asked what is being done regarding long-term care concerns for the uninsured. **Ms. Herrera** said that ALEC has model legislation regarding a long-term care partnership. **Mr. Cauchi** said that **Mr. Steve Moses**, President of the Center for Long-Term Care Financing would be a good person to contact for this information.

In response to a question from **Representative Bilbao, Ms. Herrera** said that financing the California plan would involve increasing the reimbursements to doctors and hospitals and then taxing them an additional 2% and 4% respectively.

Senator Cameron commented that there is a need to work on the overall wellness issue. He asked whether there are states doing this and what are they doing. **Mr. Cauchi** said he would get more material for the committee. He noted that the private market is more focused on this. **Ms. Herrera** explained that the West Virginia Medicaid plan includes a personal responsibly act that people sign saying they will comply and follow all requirements of disease management. If this is signed the person gets a very good benefit package. **Mr. Cauchi** said it has only been in the last three years that wellness plans have come into focus.

Senator Cameron said there have been significant increases in health insurance premiums and increases in administrative costs and reserves for insurance carriers and asked whether there were any publications that compare what other state carriers are spending in administrative costs and so on. **Ms. Herrera** referred to the Council for Affordable Health Insurance.

Senator Corder asked for positive examples of incentives for small business to take care of the problem themselves. **Ms. Herrera** referred to the Index of Health Ownership and **Mr. Cauchi** commented that a few states have passed laws specific to small business and he would get that information for the committee.

Senator Corder said that it does not seem logical that Idaho is ranked fourth for health insurance. He asked what the state is doing right or wrong. **Ms. Herrera** said that she would provide the committee with the criteria that led to that ranking.

Representative Block commented that in some of Idaho's reform packages there are health savings accounts that reward Medicaid participants for behavior modification. She asked for information from other states that have offered this type of incentive. **Ms. Herrera** said that Florida is the best state to look at at this time. She said their Agency for Health Benefits has some interesting reports on the state's website each quarter that lists how the total incentive package is doing. She said they do offer a certain amount of incentive dollars ($150) that people can spend on certain health products.

Representative LeFavour asked whether an economic analysis had been done in relation to the free market breakdown. **Ms. Herrera** said she did not have that information. She did comment that in her opinion the Wisconsin plan will become too expensive and will lead to rationing of health care.

Patti Campbell, Department of Health and Welfare was introduced to give the task force an update on the Access to Health Insurance and Chip B plans. **Ms. Campbell** began with a recap of some basic elements of the programs and then reviewed some data.

Ms. Campbell explained that the Access Card provides premium assistance to children up to

$100/person/month or a maximum of $300/family. The parent can choose an insurance plan of their choice. The plan can be an individual policy or they can add the child to their group plan. The family is responsible to pay the copays and deductibles of the plan. This program was implemented in July 2004.

She said that the Access to Health Insurance Program was implemented a year later in July 2005. This program provides premium assistance for employees of small businesses, defined as 2-50 employees. The employee, spouse and children can have their premiums offset by up to $100/person or a maximum of $500/family. The employer can also qualify for premium assistance for themselves and their family members if they meet the income criteria. The program is limited to 1,000 adults; there is no cap on the number of children who can participate.

Ms. Campbell stated that Children's Health Insurance is a state direct coverage program for children under age 19 who do not qualify for the standard Title XXI Medicaid program. This is a state insurance program where we pay for all the covered services, in contrast to the other two programs where we only help pay for the premiums. Depending on income, the family is responsible to pay a monthly premium to the state which is $10 or $15. Families can choose direct coverage or opt for premium assistance for their children.

To qualify for these programs, family income must be below 185% of the federal poverty guideline (FPG) and they cannot have insurance at the time of application.

These programs are matched with 80% federal funding. The 20% match is drawn from the premium tax fund for the premium assistance programs, and the direct coverage programs if the family income is greater than 150% of the federal poverty limit (FPL).

Ms. Campbell noted that in the last year, four changes were made to the programs:

- In July 2006, the CHIP-B benefit package was changed to match the Basic Plan Benefits for Medicaid Reform initiatives.
- In December 2006, Premiums of $10/person/month were added for individuals who choose the state direct coverage and whose family income is between 133-150% of the federal poverty guidelines. Individuals with family income greater than 150% FPL have always been required to pay a premium of $15/person/month.
- In January 2007, we modified the contribution requirement for employers who participate in the Access to Health Insurance Program. Prior to January 2007, employers were required to pay 50% of the spouses' premium. This requirement was removed through state law, and subsequently approved by CMS in December 2006.
- In January 2007, the Preventive Health Assistance Program was added for individuals who are responsible to pay premiums. This program encourages prevention and wellness, as well as providing a safety net for paying premiums. Children who are required to pay a premium are automatically enrolled in the program. Program participants can earn points by keeping their well child checks and immunizations up to date. These points can be used to pay their delinquent premiums or if their premiums are satisfied, the points can be used for health/wellness activities.

Ms. Campbell explained that there are three planned activities for these programs:

- Marketing. There are approximately 7,500 children who can potentially qualify for these programs who do not have insurance and the Department is beginning to work with stakeholders to do some marketing for these uninsured children.
- A contract with BSU to do a study of six states' premium assistance programs. The purpose of this study was to identify best practices in other states that Idaho may want to adopt. The report has just been received, and is currently being analyzed and the Governor's Office is making recommendations.
- Analyzing the feasibility of coordinating and consolidating applications with other means-tested programs. As an example, the school lunch program, Head Start and WIC, all review income to determine if individuals qualify for their programs. By consolidating these efforts and applications, the application process may be streamlined.

Her handout also showed the following data:

Premium Assistance / Direct Coverage through Title XXI:

Program	Number of Eligible Children
Direct coverage for Title XXI children up to 150% of the FPL	15,756
Direct coverage for individuals 150-185% of FPL	3,166
Access Card	51
Access to Health Insurance	402 (293 adults & 109 children)
Total	19,375

Preventive Health Assistance (PHA) / Premium Collection	
SFY 2007 total premiums collected	$348,181
Number of children currently required to pay a premium ($10 or $15)	6,174
Number of children who have earned points for well child checks and immunizations	2,101 out of 5,707 children
PHA points ($) paid for delinquent premiums	22,547 points ($22,547) for 729 children
Number of individuals with premiums delinquent over 60 days (have not earned PHA points; notification sent of ability to earn points)	527
Number of children closed for not paying premiums and not earning wellness points (since implementation of PHA)	6

Access to Health Insurance

Employer information	
Number of participating employers	54
Number of employers who dropped insurance in last year (chose not to renew)	51

Senator Cameron commented that it was his understanding that Idaho has received more premium tax and federal match money than what the state can expend. **Ms. Campbell** stated that amount rolls over each year and accrues. In response to a question from **Senator Cameron, Ms. Campbell** stated that Idaho has received about $8.9 million in premium tax that does not include the 80% match.

Representative Rusche asked whether the category "Number of Children Enrolled" means those that are enrolled and asked whether there is data for the number of children eligible but not enrolled. **Ms. Campbell** said that while there are no hard numbers for this, the department does have an estimate of the number of children eligible but not enrolled.

In response to a question from **Senator Lodge, Ms. Campbell** said that data regarding the number of participating employers in the Access to Health Insurance Plan was over 100 at one time. Currently there are 54 enrolled and 51 have dropped off. **Representative Henbest** asked whether there was detailed information about why employers have dropped out. **Ms. Campbell** said there are not good data available. Most just drop saying they cannot afford it and withdraw.

Leslie Kelly-Hall, Vice President/Chief Information Officer, St. Alphonsus Regional Medical Center was introduced to give a status report from the Health Quality Planning Commission on the Health Data Exchange. **Representative Rusche** also took part in the presentation. This complete PowerPoint is available from the Legislative Services Office.

Representative Rusche explained that the Health Quality Planning Commission was designed to put various players in the health care system together to address the better use of health information to improve the quality and efficiency of the health care system and to review the health care system for other opportunities to improve quality. He said there was a delay in getting the commission up and running due to a delay in the appointment of members. The commission includes members from Blue Cross of Idaho, Regence/Blue Shield of Idaho, St. Lukes, St. Als, Clearwater Valley Hospital and Kootenai Hospital. It also includes three physician members, a faculty member, a pharmacist, a member of the Idaho Employers Health Coalition and a manager of a community clinic. Former **Senator Compton** is the chairman of the commission.

Representative Rusche said there is a clear recognition that there is good cooperation between health insurance, hospitals and physicians. There is an interim report out showing that progress has been made toward the charge given the commission by the Legislature.

Ms. Kelly-Hall stated that the Health Data Exchange is being developed due to the fact that although largely interdependent, health care providers, payers and the patients they serve continue to operate in isolated domains. She said health care providers are often at cross purposes and are disconnected operationally with unequal levels of automation and data sharing. There is no framework for collaborative problem solving.

She noted that interdependence without collaboration or tools causes the costs of health care to increase due to:

- Duplicate testing
- Inappropriate care
- Safety issues
- Quality issues
- Inadequate coordination of care
- Information is difficult to attain

Ms. Kelly-Hall explained that the Health Data Exchange will provide:

- An electronic post office for the routing of information
- An electronic bucket for the retrieval and storage of information
- An electronic traffic cop to direct and secure access and movement of information
- One electronic door to all information sources

Ms. Kelly-Hall explained that although retail pharmacy is highly automated, pharmacy data is largely unavailable to providers today. Providers rely on patient memory and manual information gathering. Errors and increased costs result. She said the Health Data Exchange will allow providers access to pharmacy history in all care settings and the ability to electronically write prescriptions.

With regard to the Health Data Exchange, consensus has been reached in the following areas:

- Business model
- Sharing of data
- Data architecture
- Functionality
- Governance

The PowerPoint includes a chart showing the estimated costs savings to Idaho. **Ms. Kelly-Hall** cautioned that the total estimated savings of $36 to $40 million was taken from a study done in Oregon by a similar commission that looked at what the avoided costs potential would be in a setting with complete medical records available. The estimate also includes information from one doctor's study of how many phone calls his office takes just regarding prescriptions, refills, errors, legibility and so on. This was determined to be a significant cost, just in one practice.

Ms. Kelly-Hall noted that these estimated savings are quite large and the potential for saving those costs are real but still requires a leap of faith and a lot of cooperation and collaboration from commission members.

The Commission's next steps include:

- Draft recommendation
- Public comment
- Final recommendation
- Technical team leaders determined
  - Teams formed
  - RFP generation and review
- RFP phase
- Idaho Health Data Exchange formed as a 501(c)(6)
- Pilot project
- Implementation

Ms. Kelly-Hall said the initial next steps include presentation of the final report. There will be a need for additional legislation to help establish the Health Data Exchange authority and policy. She stated that the good news is that there are significant stakeholders working together for a common goal to improve health care, reduce costs, and provide clear policy for the future.

Representative Henbest asked about the model being used for the 501(c)(6). **Ms. Kelly-Hall** said that is still under discussion. One side of that discussion is that the Health Data Exchange should not depend on government or on grants. The discussion is that it should be based on a business model with modest returns so the Health Data Exchange can continue to grow and prosper independently. She noted that they have been seeking, through Medicaid, some grants that would help affect funding needed but that is not a condition of getting started. It is estimated that the initial pilot project will cost between $700,000 and $800,000, with a long term cost of $2.5 to $3 million annually. This is compared to other states' costs that are much larger. The commission has been very clear to keep things simple and to deliver on the promise and to solve the need that has been articulated. It is believed that there is funding available and there has been discussion of loans being provided to the Exchange.

Representative Henbest said that in her opinion, the savings in the program will be realized by the payers not the providers. **Ms. Kelly-Hall** said the data from the study done in Oregon shows that benefits are actually provided to both fairly equally. The rationale is that there are two potential savings areas. The first is a reduction in administrative costs that will largely benefit the providers. The second is the reduction of the actual cost of assistance where the payer, the employer and the patients see the benefits.

Representative Marriott applauded this idea and said that he thinks this is a good program. In his opinion his medical record should be available to any physician he sees. He asked if the concept of a "smart card" as used by the military was considered instead of a data exchange. **Ms. Kelly-Hall** said yes and that it will be a tool in the future. She continued that in order to use a smart card, the data has to be able to be updated. She said that infrastructure for updating such a card is not available yet. The idea is to allow the data to remain in the system where it originated as well as to be moved to a central information file. The military uses a smart card currently.

Senator Werk stated that the Health Data Exchange pilot project will be pharmacy related. He commented that the Board of Pharmacy is working on a database and wondered if that would be a duplication of effort. **Representative Rusche** explained that the Board of Pharmacy database is only for controlled substances so it is a different process. He noted that it could be fed information from the Health Data Exchange. He also commented that the commission felt it was important to keep the records where they were generated but allow access to that information when a person visits a new or different doctor. This is an automated delivery system for a physician to use.

Senator Goedde asked whether pharmacies price drugs competitively. **Senator Goedde** said in his opinion, if patients could shop the drugs they take as a package, that would result in cost-savings. **Representative Rusche** said that once a mechanism is in place to exchange information it could allow for the shopping of prices. Utah has a Health Data Commission that studies different procedures or pharmaceuticals to see if they have been handled appropriately. He said an additional value of the Health Data Exchange is in the fact that it would allow for collaborative agreements among many of the players in the health care system that they will enforce on themselves.

Senator Cameron said that most carriers in Idaho are contracting with pharmacy providers that collect data on different drugs people take. He asked how those data collected by the private sector interface with the above and whether government will be duplicating those efforts. **Ms. Kelly-Hall** said these are not at cross purposes and are quite complimentary. The Health Data Exchange will provide the care provider with comprehensive data so better decisions can be made at the time care is taking place.

Senator Corder said that one objection he heard to the Health Data Exchange idea was that providers could lose their competitive edge. He asked who reached this consensus. **Ms. Kelly-Hall** said it included members from Blue Cross of Idaho, Regence/Blue Shield of Idaho, St. Lukes, St. Als, Clearwater Valley Hospital and Kootenai Hospital. It also includes three physician members, a faculty member, a pharmacist, a member of the Idaho Employers Health Coalition and a manager of a community clinic. She said the commission members have moved from the idea that they are disadvantaged if they collaborate. She said they seem to have realized that the quality of care is more important and have focused on common interests and risk.

The next item on the agenda was a panel discussion regarding recent increases in health insurance rates from **Jack Myers, Executive Vice President/CFO, Blue Cross of Idaho, Jim Pinkerton, Manager of Actuarial Policy, Regence Blue Shield, Elwood Kleaver, CEO and Norm Varin, Director of Underwriting and Risk Management, Primary Health.** Their complete PowerPoint presentations are available from the Legislative Services Office.

Representative Henbest commented that each presentation contained very general information and asked what was meaningful for Idaho and what was based on national trends in terms of costs and utilization. **Mr. Myers** said that his last few slides contained data specific to Idaho. He noted that Task Force members might be concerned about significant price increases for Idaho

nongroup individual family contracts and agreed that those did increase quite significantly. He said that in studying this, Blue Cross found that one thing that was affecting that pool was a significant change in high cost cases.

Mr. Pinkerton explained that typically a carrier would do a study on a specific pool and develop a trend that they believe was appropriate to that pool. This could be done on any number of issues including economic influences and so on. He said that national numbers are just a general trend. **Representative Henbest** registered her disappointment because, in her opinion, Idaho has problems.

Mr. Varin explained that Primary Health has a 12.5% trend with small group insurance and that large group generally sees a different trend.

Senator Cameron commented that all members of the Task Force are concerned with health insurance premium rates. He said seeing baseline increases of 24% with no national data to back that up makes something seem amiss. He said he heard a comment about it being underpriced but that money is still being put into reserves. **Mr. Myers** said that in 2007 the 10.27% trend was the trend across the fully insured line based on experience of each specific pool. Applying that trend to actual experience over a time period is what results in a 24% increase and when an age factor is included that can even be higher. **Senator Cameron** said it seems like these factors are being compounded when actual claims experience is included. In his opinion, the consumer gets hit twice to get the carrier ahead of the curve.

Mr. Myers said there needs to be a separation of cost trend and pricing trend. Cost trend is what is observed as there are increases in claims cost. Pricing trend is what is expected to happen in the future based in part on what is seen in cost trends. He said there might also be data that indicate the pricing trend should be above or below that number. That overall trend is applied across the entire population of the fully insured. Currently cost trends are 11.5% and price trends are 10.25%. He said they are not purely looking at what historical costs would dictate.

Senator Cameron asked if this has gone back to a pooling system, that the state wants to avoid, in order to ratchet up the rate further. **Mr. Myers** said no. He said they were interpreting the Idaho Code to allow certain pools to be broken up. He noted they are using one pool for everyone in the nongroup pool.

Representative Rusche asked whether the increased number of high cost cases is numerator or denominator driven. **Mr. Myers** said that is the average cost per member not volume. **Representative Rusche** asked whether this is not an indication of the fact that lower cost members are dropping out and less healthy higher cost members are staying in and driving up the costs. **Mr. Myers** said he does not believe that this is a contributing factor.

Representative Rusche asked for an explanation of credibility and the risk charges. **Mr. Pinkerton** said that pooling involves achieving a pool that has credible results from year to year. On average, it is very predictable but when risk charge is added it is necessary to decide how

much tolerance for risk exists. A decision is made on the number of claims to cover above a certain amount. This is added into the rate. The more credibility, the smaller the risk charge.

Representative Rusche asked whether risk charge for the small group pool is being added on above the trend. **Mr. Pinkerton** said he was not sure and that could be proprietary information. **Mr. Varin** said that the risk charge helps level claims charges going forward and keeps rates at moderate increases instead of having one large increase at a certain time. **Mr. Myers** commented that Blue Cross tends to look on a long-term basis to have between 2% and 3% underwriting to maintain risk based capital. He said in 2006, Blue Cross earned about 3% and this year that will be about 1%. He said over the last ten years their average has been about 1.69%.

Senator Corder said he had heard in general that costs have increased the same as the CPI. **Mr. Myers** said he included a slide that indicated a variety of components driving health care that included CPI. He noted there are other reasons why prices are higher besides the CPI. **Senator Corder** asked why not put all groups/pools together and take the average. **Mr. Myers** said the pools he discussed were across all fully insured lines of business; large, medium, small, nongroup. He said the trend would be applied to the different experience levels within each of those pools. He said in the nongroup areas, they are using one pool. The medium and large areas are each considered one pool but each account has its own experience. **Mr. Myers** said that taking the average of all of the pools would result in a community rating and if everyone has the same rate, those with small health care needs drop out because it becomes too expensive to pay for the higher risk people and that leaves the higher risk people in the plan and makes it more and more expensive.

Representative Wood asked, of the three factors that drive trend (utilization, costs and mixed), and assuming those have an aggregate of 100%, what is the breakdown in the percent each contributes to trend. **Mr. Myers** said that his first slide shows this breakdown. It shows the general price increase at 2.4%, the price component above and beyond CPI is another 2.6% and utilization increase is 3.8%. **Representative Wood** asked for more clarification. **Mr. Varin** said that would depend on the type of service being looked at such as hospital or outpatient and so on. He said the aggregate could be close to 40% cost, 40% utilization and 20% mixed. He said for hospitals it could be 60%, 30% and 10% and for outpatient it could be the opposite. In response to another question from **Representative Wood, Mr. Varin** said the fastest growing component in aggregate is cost.

Representative Wood asked for comment, with respect to both cost and utilization, on what effect or role capacity or the lack thereof has in providers of all types. He also asked for comment on what role self-referral plays within providers of all types in terms of driving the cost and utilization. **Mr. Varin** said that an earlier presentation explained that the cost component is not controlled in Idaho because of the lack of provider competition. More capacity to compete gives providers more incentive to do a better job with services they offer and to provide service at lower cost. He said he was not sure what the question about self-referral was getting at but that in Idaho it is generally up to the individual to seek the care they think is appropriate.

Representative Henbest commented about the issue of cost shifting by Medicare and Medicaid, and said that insurance companies also negotiate rates for certain employers and providers and this could also cause cost shifting. She asked whether it is legally possible to cost shift among new groups. She asked whether carriers cost shift individual/small group and large group by negotiating a better rate for a certain group. **Mr. Varin** said that on behalf of Primary Health the negotiation with a provider is a flat negotiation for their services regardless of who they see. It is his understanding that this type of negotiation is not mandatory and thinks they could negotiate certain prices for certain companies and give providers different reimbursement rates. **Mr. Myers** said they have had examples in the past where an employer decides they want to reduce costs and decides to send all employees to certain providers. In these cases, the carrier goes to the provider and asks for special rates and offers special reimbursement.

Senator Cameron said a challenge for the Health Care Task Force will be the definition of trend because carriers have different definitions. He said he had asked how much of the baseline rate increases that are being seen for small group is trend line versus catch up versus getting ahead. He said he would also like to see the history of administrative costs and where those have been in the last ten years as well as a history on reserves including where they are currently and what is the goal. He would like to know what is appropriate for carriers. He would like this information to be presented at the next meeting.

Senator Cameron asked other task force members to submit ideas for future meetings to the Legislative Services Office.

Bill Deal, Director, Department of Insurance was introduced to discuss a summary of laws applicable to individual health insurance rate increases. His complete PowerPoint is also available from the Legislative Services Office. **Director Deal** began his presentation by introducing his staff and commending them for all of the work they do.

Director Deal explained that Idaho regulates health insurance rate increases for individuals and small employers (less than 50 employees). He stated that the laws governing rate increases for individual and small group health insurance policies are essentially the same and are based on a model act developed by the National Association of Insurance Commissioners (NAIC).

Director Deal explained that rate bands are a statutory method for requiring that insurers spread health costs and risks between healthy persons and less healthy persons. Rate bands limit the difference that can exist between the highest rate charged and the lowest rate charged to individuals with similar case characteristics. (Case characteristics are: age, gender, geographic location and tobacco use.) He said that in the beginning of using rate bands it was believed that this would be a method of spreading the costs of health care between the healthy and the less healthy. It was thought that these bands would limit the difference between the highest rate charged and the lowest rate charged.

Idaho's rate bands are 50%: The highest rate cannot be more than 50% higher than the average between the highest and lowest rates (known as the index rate), and the lowest rate cannot be

more than 50% lower than the index rate. This creates a cap on the maximum amount a person can be charged. If the index rate is 100, then the maximum rate is 150 and the minimum is 50.

States that use rate bands generally set them at 20% or 25%. Prior to 2000, Idaho used 25% rate bands, meaning the highest rate could not be more than 67% higher than the lowest. The law was changed in 2000 for the purpose of allowing insurers to offer lower rates to younger, healthier persons in an effort to increase the number of insured in Idaho. Now the highest rate can be three times as much as the lowest rate charged.

Section 41-5206(1)(b), Idaho Code, states that the percentage increase in the premium rate charged an individual for a new rating period may not exceed the sum of:

- The percentage change in the "new business rate," plus
- An adjustment not to exceed 15% annually due to claim experience, health status or duration of coverage, plus
- Any adjustment due to change in coverage or change in case characteristics. (Case characteristics are age, gender, tobacco use and geographic location)

The "new business rate" is the lowest rate charged by the insurer to individuals with similar case characteristics; i.e. the insurer's best rate. It is sometimes referred to as the "Base Rate." An increase in the New Business Rate will result in increases for all policyholders.

The new business rate increase is often referred to as "trend" since it tends to track changes in health cost trends; however, Idaho's rating laws do not use this term or define how the new business rate increase must be calculated.

Director Deal discussed the Department of Insurance review of new business rate increases. He explained that section 41-5206(1)(d)(I), Idaho Code, states that:

- *Rating factors shall produce premiums for identical individuals which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the individuals assumed to select particular health benefit plans…".*

He explained that the Department interprets these requirements to mean that the new business rate increase should be roughly uniform among all the insurer's plans since the increase may not be based on the health experience of the persons selecting or assumed to select a particular plan. Administrative Rule 72.036.16.d requires that an insurer make a special explanatory filing with the Director if the new business rate increase for any plan will differ from any other plan by more than 20%. This limits the ability of insurers to selectively apply the new business rate increase to particular plans to force persons out of those plans and into plans that may be more profitable for the insurer.

Director Deal went on to explain that in addition to the New Business Rate Increase, which is applied to all plan members, section 41-5206(1)(b), Idaho Code, permits insurers to also apply individual rate increases based on each individual's (or dependent's) claim experience, health status or duration of coverage. This risk-based increase is limited to 15% per year.

Director Deal said that although the 15% limitation seems simple on its face, because the intent of the law is that this be a separate increase from the New Business Rate increase it is important to note that any rate increase due to health factors be applied in a manner that is not multiplicative of the New Business Rate increase. Rule 72 sets forth a special formula for calculating the maximum rate increase attributable to claims experience and health status that is aimed at avoiding the multiplicative effect that would occur by simply adding 15% to the New Business Rate increase. Rule 72 is based on a model rule developed by the NAIC.

Shad Priest, Department of Insurance gave the following examples:
New Business Rate (NBR) Increase of 25%:
2006 NBR: $200
2007 NBR: $250

Current Monthly Premium:
Person X 2006 Rate: $480/month
Person Y 2006 Rate: $380/month
Assume that X and Y have identical case characteristics (age, gender, location & tobacco use) and there is no change in case characteristics. What is the maximum increase for X and Y for 2007?

Approach #1
Maximum Increase = NBR Increase(25%) + 15%
Person X:
$480 + 40% = new premium of $672/month (monthly increase of $192)
Person Y:
$380 + 40% = new premium of $532/month (monthly increase of $152)
Under this approach, the higher a person's starting premium, the greater the impact will be from any new business rate increase, despite the intent of the law that the new business rate increase not take into account health factors.

Approach #2
Rule 72.036.17 and NAIC Model Rule
Maximum Increase = New Business Rate ($250) multiplied by:
One plus the sum of:
Percentage actual 2006 rate was above the 2006 NBR (this is known as the "risk load") and 15% (the maximum increase allowed for experience and health).
Person X:
1 + 140% (2006 risk load) + 15% = 2.55
2.55 x $250 = new rate of $637.50 (monthly increase of $157.50)
Person Y:
1 + 90% (2006 risk load) + 15% = 2.05
2.05 x $250 = new rate of $512.50 (monthly increase of $132.50)
Under the Rule 72 approach, the increased new business rate is used as the starting point for calculating the risk adjustment. A maximum of 15% is added to the prior year's risk load, which

is applied to the new business rate. The net result is that the effect of the new business rate increase is more evenly distributed among plan members. In this example, rather than each person receiving a 40% rate increase, X will receive an increase of around 33% and Y of around 35%.

Mr. Priest noted that the primary purpose of the Small Business Act and the Individual Health Insurance Act that were passed in the 1990s was to increase access to health insurance but they were not intended to be a solution to affordability. In his opinion these acts have been very successful on the access side because every single individual or small employer can purchase health insurance, if they can afford it.

Senator Cameron commented that maybe Idaho's current process for determining rate increases needs to be reevaluated. He asked the department to look at this and make sure the proper tools are available and to make sure the state is able to protect the consumer as well.

Representative Henbest noted that the question when the rate bands were expanded was whether it actually brought more young and healthy people into the market. She said currently she is not sure if this was a success. **Director Deal** said he personally thinks the rate band issue needs to be on the table and that he is not sure it did bring in the young and healthy into the marketplace.

Representative Henbest commented that the new business rate increase due to health factors has to be applied in a manner that is not multiplicative of the New Business Rate increase but that trend actually includes some health factor experience. She asked whether there should be more constraints against that happening. **Mr. Priest** said that was a valid concern. He stated though, that the real ceiling rate on these increases is competition because the new business rate has to be equally applied to all products unless there is justification other than the health experience. In his opinion, in order to stay in business, the New Business Rate has to be at a price that will attract people into their plans.

Senator Stegner commented that he would welcome more discussion of rate bands. He said that originally the law was to raise the rate bands for two years and to put them back to 25%. He stated that rate band information is very difficult to get and now he is more inclined to keep the rate bands where they are because when rate bands are narrowed, more low risk people drop out. He said that broadening the bands eliminated some of that low risk drop off.

Representative Rusche said that as they look at rate bands he would also like to review what to do with high risk/high cost individuals. **Senator Cameron** said there would be a presentation on the high risk pool at a later date.

In response to a question from **Representative Rusche** regarding the duration increase of 15%**,** **Mr. Priest** said the Department does not have information on what carriers are using on those for increases and that it could be proprietary information. He said that the law reads that they

can look at duration, health status and claims experience. **Senator Cameron** asked whether 15% is the floor. **Mr. Priest** said he did not think so.

Representative Marriott asked for clarification of the index rate. **Mr. Priest** explained that the rate bands move based on the index rate. He said they take the highest and lowest rate, add them together and divide by 2. **Mr. Priest** said this changes every year because if the floor rate increases, the ceiling can increase by three times.

Senator Stegner was introduced to give a report of the Mental Health Subcommittee. He said the focus of that subcommittee at this time is on commitment laws and review of the capacity of the state hospital system in Idaho.

After closing remarks and discussion, the next meeting of the Health Care Task Force was scheduled for August 27, 2007.

The meeting adjourned at 4:51 p.m.