Minutes
Health Care Task Force
Wednesday, October 31, 2007
9:00 a.m.
J.R. Williams Building, East Conference Room
Boise, Idaho

The meeting was called to order by Cochairman Representative Gary Collins at 9:05 a.m. Other committee members present were Cochairman Senator Dean Cameron, Senator Joe Stegner, Senator Patti Anne Lodge, Senator John Goedde, Senator Tim Corder, Senator Elliot Werk, Representative Carlos Bilbao, Representative Fred Wood, Representative Jim Marriott, Representative Margaret Henbest and Representative John Rusche.

Others present were Tim S. Olson and Therese Bishop, Regence/Blue Shield; Julie Taylor and Woody Richards, Blue Cross of Idaho; Joel Fisse, St. Luke's; Molly Steckel, Idaho Medical Association; Reid Olsen, Meridian School District; Becky Crofts, Middleton School District; Susan Morrison, Wilder School District; Jim Baugh, Comprehensive Advocacy; and Kent Kunz, Idaho State University. Legislative Services Office staff members present were Eric Milstead and Toni Hobbs.

After opening remarks from the cochairmen, **Representative Wood** moved that the minutes from the last meeting be approved. **Representative Bilbao** seconded and the minutes were approved by voice vote.

Ms. Patti Campbell, Department of Health and Welfare was introduced to give an update on the Health Insurance for Adults and Children Program in Idaho. **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 for 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 to 50 employees. The employee, spouse and children can have their premiums offset by up to $100/person or a maximum of $500/family. Employers 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.

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

mean that a family of four's maximum gross monthly income would be $3,184.

Funding for these programs is primarily from federal Title XXI programs. These provide an 80% match rate. The other 20% match is drawn from the insurance 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 said that there is a total of 464 people participating in the programs; 126 children, 262 adult employees and 76 adult spouses. She said in order to increase these numbers the Department has contracted with Boise State University and Milliman Consultants to survey other states to learn of other premium assistance programs to see if there might be policies Idaho wants to adopt. This survey looked at Oregon, Pennsylvania, Illinois, Maine, Utah and Michigan programs. She distributed a handout that identifies some modifications that Idaho might want to look at to help low-income children and individuals who do not have insurance or cannot afford coverage. **Ms. Campbell** described the following three potential modifications that might be considered for the state's current system.

The first modification is to offer premium assistance for employer sponsored insurance regardless of the business size. The reason for this change is due to the fact that many small businesses are unable to afford the high cost of premiums for their employees and they frequently employ part-time or seasonal employees who are not eligible for health insurance. Based on Oregon's experience, impact on Idaho for this change could be up to 6,176 children and adults over a four-year period.

The second modification is to use Title XIX funding to allow insured individuals to get help with premium assistance. **Ms. Campbell** said this has been a recommendation of the Task Force in the past. This would be for those individuals who have insurance at the time of application. Title XXI law restricts individuals from accessing premium assistance coverage if they have insurance at the time of application regardless of whether or not they can afford the coverage.

She explained that states can use Title XIX funds for this coverage through a CMS waiver request but need to demonstrate that this change would not increase Medicaid program costs, which is called budget neutrality. Idaho could demonstrate budget neutrality by reducing the annual increase of disproportionate share hospital (DSH) funds paid to the DSH hospitals. This money could then be used to fund the premium assistance program for insured individuals while demonstrating budget neutrality for CMS. It is estimated this policy change will result in a total enrollment of 2,100 individuals at a cost of $100 per member per month. The projected uptake in four years would be 1,680 enrollees at a projected cost of $2,016,000.

Ms. Campbell noted that state law changes would not be necessary for this modification, although rules and a CMS waiver approval will be required.

Modification number three is to coordinate marketing to broaden awareness of the premium

assistance programs. Considerations for this modification include ways to:

- Identify and promote premium assistance options in Idaho Health Plan outreach materials.
- Collaborate with Department of Commerce and other key stakeholders in outreach and marketing efforts.
- Establish sustainable communication avenues with employers in order to provide accurate and timely information.
- Focus outreach and marketing efforts to target working families.
- Leverage resources through public/private partnerships that can facilitate and extend outreach and enrollment activities.
- Consider engaging a full-time service marketing and advertising company to facilitate successful marketing and communications efforts.

Ms. Campbell noted that it is difficult to determine at this time how many additional families marketing efforts alone will add.

Ms. Campbell said there are funds available in the premium tax fund due to the low enrollment in these programs. From the time the program was implemented in 2004, funds have continued to be carried over from year to year. The estimated balance as of June 30, 2008, is $12,367,900.

In response to a question from **Representative Rusche** regarding CHIP B, **Ms. Campbell** said there were 17,000 children in those programs for direct coverage. CHIP B is where Idaho actually pays the bill, while the access program is premium assistance.

Senator Cameron said that the money in the Chip B column is for children between 150% and 185% of the federal poverty level. He clarified that the dollars shown here are simply premium tax dollars. He said adding 80% to these figures is the amount of money being left on the table that is available to be spent for health insurance.

Ms. Campbell said she would get information regarding the number of applicants and the number of denials for the Task Force. She said that has not changed from previous reports. She commented that she wanted to focus on the recommendations from BSU. **Senator Cameron** said he had heard that there have been some groups that have enrolled employees because they fell under the poverty level. He said as these good employees are paid more, they no longer qualify for the program. It is his understanding that some do still maintain coverage but without assistance from the state, others drop out.

Senator Corder asked what prevents us from changing the185% standard. He suspects many businesses do not qualify for this because they pay better than that. **Senator Cameron** said that is set by state statute and that there has been contentious discussion of where that limit should be. He said this discussion is on a national level. Some states set the limit beyond 200% of poverty and federal recommendation was no higher than 200%. He said that 185% was chosen because that is the level for the free and reduced school lunch. He added that many children get free lunches who are not participating in this program.

Representative Henbest clarified that the federal recommendation was no more than 250% of poverty level.

The next agenda item was a panel of school board members. Reid Olsen from the Meridian School District, Becky Crofts from Middleton and Susan Morrison from Wilder were introduced to discuss public schools health insurance issues from a school board perspective.

Mr. Olsen clarified that he planned to provide the Task Force with an idea of the process the school district goes through in purchasing health insurance.

He said that Meridian has a committee of eight people: two are members of the school board association, two are members of the district, two are administration members, one, a retired member and one, a member at-large. This is the committee in charge of purchasing insurance.

At the beginning of each year, this group is tasked with negotiating with various insurance companies for the coming year. Whatever is negotiated with the insurance company has an impact on what they are able to do as far as salaries and other benefits. **Mr. Olsen** said that, to date, these negotiations have worked quite well. **Mr. Olsen** said that the Meridian school district received a 13% increase in health care costs, and that was better than they thought it was going to be. He noted that they did not have to increase their deductibles or copays for this rate. He said that due to the size of the district, Meridian is able to negotiate a better rate.

Ms. Becky Crofts, Middleton School District #134 said Middleton is a medium sized district with about 300 teachers. She said that the trend for them has increased and from 2001 to 2008 they have seen a 100% increase in costs. Premium costs for an individual teacher were $173.30 in 2001, and have increased to $340.50 in 2007. They have had a 22% to 29% increase each year.

Ms. Crofts said that in 2001 the deductible was $200, a 90% coinsurance and $1,500 out of pocket maximum. Today, in order to keep costs somewhat manageable, they have a $750 deductible.

For the employee to add family, they would pay about $500 additional out-of-pocket per month. Without increasing their deductible, the district would have seen an 18% increase in medical costs alone. Increasing the deductible kept the increase to 9.2%.

Ms. Crofts noted that currently the state provides funding for salary increases but not for health care increases so those costs are absorbed by the district. She said that Middleton does not run supplemental levies for benefits or salaries. She said this is a concern because their fund balance continues to get smaller. This is particularly concerning because the district needs a new high school and in order to get the appropriate rating, they have to maintain certain fund balances, and having to cover the increased cost of health care reduces that fund balance.

She said that there is a point of contention during negotiations in the district when the state gives

a 3% salary increase, and the district only offers a 2.16% salary increase due to insurance rate increases. District employees do not realize that insurance coverage is actually part of the entire salary and benefit package.

Ms. Susan Morrison, Wilder School District explained that in her district, twenty years ago, through the bargaining process as required by Section 33-1271, Idaho Code, the “farm was given away” by allowing language in the negotiated agreement to be added to pay 100% of the health insurance premiums for employees, employee spouses and employee/children or family.

She commented that having to negotiate Blue Cross benefits each year from 2002 through 2006 resulted in the following in Wilder:

- Recall of a veteran board member
- A vote of no confidence on the administration
- Bullying and intimidation of teachers by Idaho Education Association (IEA) leadership
- Community loss of trust with district and teachers
- Loss of trust among teachers
- Tactics used by the IEA and the Wilder Education Association accomplished nothing. It hurt careers, deceived staff and community, and tarnished the image of the Wilder School District.

She went on to discuss insurance premium increases as follows:

- 2002 - 10% increase (Traditional Plan $100 deductible)
- 2003 - 12% increase (Traditional Plan $100 deductible)
- 2004 - 0% increase (Traditional Plan $100 deductible)
- 2005 - 17% increase (Traditional Plan $100 deductible)
- 2006 - decrease (Change in plans from Traditional $100 deductible to PPO $100 deductible) negotiations lasted 2.5 years
- 2007 - 12% increase (PPO Plan $200 deductible)

Her handout shows premiums ranging from $292 for employees and $744 for families with a $100 Traditional plan deductible in 2002 to $383 for employees and $974 for families in 2008 with a $200 PPO deductible. She explained that the total annual premium paid by the school district in 2008 will be $217,051.

Ms. Morrison said if it were not for their annual supplemental levy each May for $180,000 and their Canyon Owyhee School Service Agency (COSSA) levy of $133,000, paid by patrons in the district, they would have no fund balance.

She explained that Blue Cross has indicated that less than six districts pay for the premium beyond the employee only. She said if that were the case for Wilder, the district would have an additional $93,153 to use for other needs.

Ms. Morrison closed by saying that it would help her district if the state were to cover health

insurance costs, due to the fact that it would allow them to allocate discretionary funds elsewhere. On the other hand, due to their conflict with the IEA, it would not help because, in her opinion, the IEA would feel as if the available funds currently allocated for health care expenditures from local revenues would be available for their interests at the bargaining table.

Due to a question from **Representative Henbest** it was clarified that most school districts do not pay for family coverage, but Wilder does because they negotiated that at some point in the past. Middleton employees pay out-of-pocket for family coverage.

Representative Henbest asked where most salaries are in each district. Meridian averages about $39,000, Middleton is about $42,000 and Wilder is between $44,000 to $49,000.

Representative Rusche commented that dropping family coverage in Wilder will only add an additional $93,000 for discretionary funds, but that those families will have to get coverage somewhere else or it will be provided as uncompensated care paid for by the communities. He said the issue is not really about insurance coverage, it is about the cost increase of coverage because it gets paid somewhere. **Ms. Morrison** said that her district is hurt by the fact that, through negotiations, they will always have the issue of family coverage to deal with. She said it will always be part of the negotiations.

Ms. Crofts said in Middleton, benefits are always negotiated and in their agreement with their association, Middleton agrees to provide certain benefits; medical, dental and so on but it does not have specific levels or limits of coverage. **Ms. Crofts** said their negotiating committee, similar to Meridian, determines the policy of how much coverage will be offered. She said it sounds like Middleton has this built in to their contract specifically.

Mr. Olson said that Meridian's deductible is $500. In response to Representative Rusche's question of costs being borne elsewhere, he stated that it would be very difficult within their negotiations to add the families on top of the employee portion.

Senator Cameron said that at the last meeting it was stated that many districts had employed different methods to reduce costs, including wellness programs and exercise. He asked, other than negotiations for price, whether anything has been done to reduce overall utilization of health care. **Mr. Olsen** said Meridian has a number of wellness programs available but he does not know specifics. He said these are not specifically geared to reduce insurance costs, just overall health. He said the results in the insurance arena will show up in claims experience, and that affects their rating. He said those programs have had an impact in that area.

Ms. Crofts said that she is not aware of any wellness programs in the Middleton district. She said they do their best to bring in flu shots clinics to keep people healthy. **Ms. Morrison** said that Wilder is similar to Middleton. She said she is not aware of any specific plan.

Mr. Olsen said that for all of the districts on Blue Cross/Blue Shield programs, the insurance

companies themselves have promoted a wellness program to all employees in the plan that is web based. He said that is accessed through the Internet so he is not sure how effective it is but it is available.

Senator Cameron commented that it was his understanding that all three of these districts were with Blue Cross at this time through the statewide fund. **Mr. Olsen** said they are not self-insured nor are they with the statewide fund. He said Meridian negotiates their own contract and are currently with Blue Cross.

Senator Corder said that a number of private employers are taking higher deductibles and buying that down to achieve considerable savings. He asked whether these school districts have considered that. **Ms. Crofts** said that Middleton did do a buydown in 2001-2002. She said that as a school district they are very concerned about rates paid and are looking to possibly shop their insurance this year. She noted that they have not done this in the past. She said they are going to begin doing more due diligence to find out where they are. This is due to the fact that some corporations that are similar in size to the Middleton School District are paying lower rates. **Mr. Olsen** said that because of the negotiations process, there is a lot of inertia to keep insurance benefits the same. He said they try to stay away from things like health savings accounts because they are hard to explain and make understandable to people.

Senator Corder said that his question was dealing with the fact that the insurance coverage stays the same and the deductible increases but the employer pays part of that difference in the deductible to keep it affordable for the employee. He said the difference in the price of the premium is what would be used to buydown that deductible. **Representative Collins** said there is a move to do this in larger corporations.

In response to a question from **Representative Wood** regarding the insurance committees and their charge, **Ms. Crofts** said that Middleton's committee reviews the policy data and decides what changes should be made in their health care coverage. This includes decisions on whether or not to increase deductibles and the like. This committee also educates each school building representative. She said this could also evolve to include wellness plans. **Mr. Olsen** said that Meridian's committee negotiates the master contract for health care.

Representative Marriott asked, since Idaho is a right to work state, whether districts can negotiate by individual teacher. **Mr. Cliff Green, Idaho School Boards Association**, said no, if teachers have voted to have IEA represent them, that group represents all teachers.

Senator Goedde commented that local education associations need to be aware that insurance coverage is part of their benefits package and that benefits are part of the total compensation package. He said the benefits can be increased at the expense of salary increases.

Senator Goedde said that it has been his experience that committees that look at medical benefits are largely composed of senior teachers that are older and might be more interested in

prescription benefits rather than maternity benefits. He asked whether young teachers are represented on these district committees.

Mr. Olsen said that Meridian tries to make it clear that the total compensation package includes health benefits. That is why they start with insurance and they discuss how much insurance cost increases impact potential salary increases. He said that their committee includes retired members, NEA members who are usually older and that the member at large is about 30 to 35 years old. He noted that teachers in his district do tend to be younger.

Ms. Crofts said that in Middleton when the state announces a 3% salary increase, teachers would like to see a 3% increase in salary. She said they do understand that insurance increases will take part of that, but no one is ever happy about that. This is discussed with employees but it is hard to make them realize this is part of the 3%. She said their committee is not unequally balanced and that the benefits offered are representative of all age groups.

Ms. Morrison said that in Wilder the board elected their attorney to represent the district in negotiations.

Representative Bilbao asked about how these districts feel about folding into the state insurance plans all employees who work in the district or just for teachers. **Mr. Olsen** said Meridian feels that they already have a better negotiated plan than what the state provides. Their plan is better and they have opted out of the state plan. **Ms. Croft** said that Middleton feels it is in their best interest to maintain negotiation ability for employees.

It was clarified that this question meant that school districts would become part of the state employee plan as opposed to the state plan for teachers. Mr. Olsen said that Meridian would not be opposed to looking at that.

Ms. Crofts asked for more information regarding what it would look like if school districts were part of the state employee plan. **Representative Henbest** said she had legislation drafted a few years ago that would have done this. She said it was drafted such that the state plan would look different than it does today. Everything would be negotiated so teachers would be able to negotiate their own coverage. She said the benefit of this would be that they would be part of a larger pool so there would be more risk sharing. **Senator Cameron** commented that there is a subcommittee meeting this afternoon to discuss options for health care coverage for teachers. He said there are a number of concerns with melding the school district employees in with other state or public employees. He said this has been done in other states. In Idaho, teachers are not typically considered state employees so that is an issue. He said there are broad differences in products and plans that make it difficult also.

Senator Goedde said that in his opinion, joining the state plan would reduce the school district employees' opportunity to influence their own outcomes as far as the cost of health care. He said they would lose control of their own destiny by joining the state pool.

In response to a question from **Representative Henbest**, **Ms. Crofts and Mr. Olsen** said they would get information regarding how many employees have added family coverage.

Paul Leary, Division of Medicaid, Department of Health and Welfare was the next speaker. Information in his presentation was requested due to House Bill 322 that was the appropriation for the Department of Health and Welfare. He distributed two reports. These are available in the Legislative Services Office.

Mr. Leary explained that House Bill 322 requested a comprehensive cost-benefit analysis of Medicaid coverage of certain substance abuse treatment. This document includes current coverage and cost to the state of Idaho for Medicaid participants receiving substance abuse treatment through the Division of Behavioral Health's contract with Business Psychology Association (BPA) and the cost-benefit impact of expanding Medicaid services to cover this treatment.

According to **Mr. Leary's** handout the total state cost in fiscal year 2006 for Medicaid participants' utilization of substance abuse services provided by the Division of Behavioral Health through contract with BPA was $1,510,545.

He explained that to get Medicaid coverage the Department would have to seek federal authority through a state plan amendment or waiver to expand current Medicaid services to include substance abuse treatment. Other states have done this successfully.

If the state were able to get Medicaid coverage, the state cost to provide the same level and volume of service would be reduced by $823,934. He said that depending on "set-aside" for the current block grant as much as $778,160 of federal dollars from the block grant may be freed up and available for services to non-Medicaid individuals.

Mr. Leary went on to discuss another comprehensive cost-benefit analysis and feasibility review of any potential benefits of paying for the therapeutic portion of Therapeutic Foster Care, residential and group care programs from the Medicaid appropriation rather than through the state funded only Children's Mental Health Program and Child Welfare Services. This is also covered in detail in a handout that is available at the Legislative Services Office.

Representative Henbest asked whether residential treatment is similar to an intermediate care facility for the mentally retarded. **Mr. Leary** said residential treatment is a residential facility that has clinical programs within it so residents get therapy while staying there.

In response to a question from **Senator Werk, Mr. Leary** said once federal funding is obtained, our state system will need to change to make sure it pays appropriately.

Senator Goedde said he was alarmed by the number of children served in 5 years almost doubling. He asked why there is that much increase. **Mr. Leary** said that he did not know. **Mr.**

Dick Schultz, Department of Health and Welfare answered that the increase in numbers is primarily associated with meth endangered children. These children cannot be placed back into their homes because it is taking longer to get parents rehabilitated and able to take care of them.

Senator Cameron said the Department's report needs further and more extensive review. He suggested having another presentation on this at the next meeting of the task force. **Representative Henbest** said the intent of this was to look at a cost-benefit analysis and feasibility review. She said there is concern that these services for the Medicaid eligible were being bought with 100% state money. She said this population could receive a federal match to free up state funds for expansion in other areas.

Mr. Laren Walker, AmeriBen Solutions was introduced to give an update on the state high-risk pool. He explained that the high-risk pool was established in 2000 and the intention was to provide availability of insurance to individuals rated either too high by insurance companies or those who were not offered insurance by carriers.

Mr. Walker distributed a balance sheet of the high-risk pool for August 30, 2006 and 2007. This information is available in the Legislative Services Office and also from the Department of Insurance and shows $14,985,796 deferred state tax funds that have not been used by the program. These fund have come from the premium tax dollars.

His handout also included an income statement of the program for the first half of 2007. Premium dollars paid by carriers accrue at about $200,000 per month. **Mr. Walker** explained that this is the first component of revenue to the high-risk pool. The second component is the premium tax dollars, and the third, if needed, is an assessment to the carriers. He noted that this third component has not been necessary. The revenues in this statement only come from the carriers with investment gains and losses.

Mr. Walker said that there is $960,424 in grant income that was received from the federal government to help finance this program. He said 2007 was the first year that the grant was available to Idaho. It is unknown as to the availability of that in the future and it has been rumored that there will not be grant money available for 2008.

Mr. Walker said that the numbers show that the pool is healthy.

Mr. Walker went on to discuss what plans and benefits are available. The following table reflects four different plans available in the high-risk pool.

Benefit Areas	Basic Plan	Standard Plan	Catastrophic A Plan	Catastrophic B Plan
Lifetime Maximum Benefit per carrier	$500,000	$1,000,000	$1,000,000	$1,000,000
Calendar Year Deductible	$500	$1,000	$2,000	$5,000
Normal Maternity Benefit Deductible	$5,000	$5,000	$5,000	$5,000
Outpatient Prescription Drugs	$250	$250	$500	$500
Benefit/Coinsurance Percentage	50%/50%	70%/30%	70%/30%	80%/20%
Individual Out-of-Pocket Expense Calendar Year Maximum	$20,000	$10,000	$10,000	$10,000

He noted that they have also developed a health savings account plan that has a $1,000,000 lifetime maximum benefit, a $3,000 deductible per individual and a 60%/40% benefit/coinsurance percentage.

His handout also included the number of lives in each plan. **Mr. Walker** stated that there are about 1,400 individuals ceded in the pool and that has been holding steady for the last 18 months. It was noted that the Catastrophic B Plan is by far the most popular. This is the plan with the highest deductible and the lowest premiums.

Ms. Joyce McRoberts, Governor Otter's Office was introduced to discuss recommendations from the Governor's Health Care Summit. She distributed handouts that explain the recommendations in detail. These are available in the Legislative Services Office and also on the Governor's website.

Recommendations were made in the following five areas:
1. Workforce
2. Comprehensive public/private health care coverage
3. Prevention and personal responsibility
4. Innovative service delivery models
5. Behavioral health (mental Health and Substance Abuse)
Each recommendation made also identified barriers and potential solutions.

She said that there has been a Governor's Select Committee on Health Care appointed through Executive Order that includes eight members. This committee has had one meeting and their first public hearing. It is their goal to create a plan with timelines over the next three or so years. This will allow them to know where they are and where they want to be along the way.

Representative Rusche asked whether they expect any legislation this session. **Ms. McRoberts** said no.

The next item for discussion was a multi-share feasibility study by **Gary Packingham, Vice President, Community Health Ventures, Inc. and Rick McMaster, Executive Director, North Idaho Health Network (NIHN).** This complete Powerpoint is available in the Legislative Services Office.

Mr. McMaster commented that this effort was initiated at the grass roots level by North Idaho communities to address the working uninsured population. He represents the NIHN and has for 13 years. This organization includes employers, physicians and hospitals. This group is committed to trying to address this problem and to improve health care quality and to save money.

Mr. McMaster said that after visiting Muskegon, Michigan and looking at their Access Health program they initiated this feasibility study in north Idaho. This was funded by the NIHN and Schweitzer Mountain in Sandpoint, Idaho. This was based on the notion in looking at the successful model that more could be done in local communities to address the cost of health care. He said there are various stages to the feasibility study and emphasized that it is not yet complete.

He explained that two crucial components of the study include how this will work financially and the authority to implement the program. He noted that they cannot go too far with the feasibility study without the authority to pilot it on a local level.

He said this is a win-win situation for employees, employers, the county, providers, hospitals and the community.

Mr. Gary Packingham was introduced to discuss how the plan actually works in Muskegon. He thanked the Task Force for inviting him and said this is the eighth state where they have talked to policymakers about what they are doing in Michigan over the last seven year. He noted

that over that time they have also learned what does not work.

Mr. Packingham gave the following history of the program.

- 1995 - The W.K. Kellogg Foundation funded a community initiative to address health needs through collaboration and created the Health Project
- 1997 - The Health Project began the collaboration process that resulted in the creation of Access Health
- 1999 - Access Health was spun off from the Health Project's community planning process and opened its doors for business as a community health coverage program

Mr. Packingham explained that the mission of Access Health is to offer an integrated community-based health improvement program for those residents who otherwise would not receive services. He said one of the first things they found was that there was not a commercial way of getting at this problem. Due to all of the mandates commercial insurance products have, the price can only be so low. That floor is still out of reach of people making between $7 and $12 an hour. He said they needed to get out of the insurance mindset and think about community resources that could fill this gap. This is called coverage, not insurance.

He said that Access Health has served local businesses for 7 yrs.

- 350 Muskegon County businesses participate
- Over 525 businesses since 1999
- Over 1,100 employees currently have Access Health
- Over 3,500 employees since 1999
- 63% of Access Health businesses belonged in the plan for more than 2 yrs
- Monthly costs for members and business have increased from 42 to 46 dollars over the past 6 years (less than 10 %)

Access Health focused on small businesses located in Muskegon County. For employee groups with medium income of less than $12/hr. the monthly cost per member is $46. The employer matches $46 and the community contributes $54. He said this covers most all health services in Muskegon County.

Benefits covered include everything from chemo, ambulance, emergency room, home care, urgent care, behavioral health and so on. **Mr. Packingham** said that the highest copay is for the emergency room at $65.00. Urgent care is $30.00 so people are incentivized to use urgent care.

Medical costs per member per month for inpatient services, emergency room services, OP hospital services, pregnancy, ambulatory, other services and pharmacy were $147.71 in 2004 and $126.94 in 2005 and $142 in 2006.

He compared the plan to a community health plan quilt using local organizations such as the Lions Club to provide care to community members. This quilt includes the Red Cross, federally qualified health care centers, dental programs and smoking cessation programs.

Mr. Packingham explained that children are allowed into the program but it is explained to their parents that it will be cheaper to use the SCHIP program. He said many do take advantage of this. Access Health actually helps get them enrolled with the state. He said they can also access Medicaid. Because they are not insurance, they have an agreement with the State of Michigan to access Medicaid coverage when it is appropriate.

He said this is basically a triangle that consists of the provider, the patient and the community. He noted that there is no finance model, no Department of Insurance, no HMO. It is just resources provided on a collaborative basis. This triangle is built on personal responsibility and the community.

Mr. Packingham said that through Access Health, the community becomes an integrated partner in the delivery of health services to previously uninsured patients. He said this plan can defuse ticking health bombs by providing previously uninsured patients with chronic diseases access to health care and thereby improve health.

He noted the following profile of Access Health members:
- 66% are smokers
- 16% have diabetes
- 18% have high blood pressure
- 24% have cardiovascular diseases
- 14% have asthma

Mr. Packingham said these are the chronic disease conditions that if not handled early, will become huge costs down the road. To diffuse these time bombs, Access Health gets them to the doctor. He said it was necessary to move these people from sick care to wellness. This plan was to focus their behaviors to more healthy behaviors.

To do this, Access Health increased their costs to $54.00 per month unless they agreed to do three wellness initiatives per year. These included smoking cessation classes, nutrition classes and exercise classes. He said that 90% of the county smoking cessation participants come from the Access Health program. He said they have 83% of the people in the Access Health program that have agreed to this.

Participation requirements in this program include:
- Health Risk Appraisal (HRA)
- 20-30 min. Health Coaching Session that includes:
    - A review of the HRA
    - A risk factor evaluation
    - Setting a Minimum of Two Individualized Health Goals
    - Picking two Health Classes to Attend
- Attend Access Health or Community Sponsored Health Class
- Attend Smoking Cessation Classes if Smoker
- Phone Call or Individual Meeting for High-Risk Members

Mr. Packingham said that this is where these people begin to change their behaviors and to start thinking healthy. This helps make them responsible financially and by adjusting their behaviors to make them understand that they are responsible for their health as well. He said there is no universal health care in his county.

He explained that in putting this together the doctors provide the treatment plan and Access Health works with the patient to make sure they are following up on that doctor's plan. This is reported back to the doctor. He said the resources are mainly focused on about 400 people that have been diagnosed as chronically ill. He said the doctors actually really like the program.

The impact of Access Health has:

- Reduced the number of working uninsured by 10%
- Created true health care management for members
- Improved the overall community health status by focusing on preventive and chronic diseases management
- Implemented 3-C Wellness program for members
- More than 83% of members chose to participate in the wellness program to improve their health
- Nationally, wellness programs have about 15% participation

The economic impact has:

- Reduced cost for uncompensated care
    - Estimated reduction of $2M per year
    - Over $12M since 1999
- Reduced turnover cost to member businesses
    - Employee turnover cost can be $2,800 to $4,000 each
    - Pioneer Resources dramatically cut turnover
    - Wee Care cut turnover 40% in first year (He explained that this program allowed this business to reduce her employee turnover by that amount)
- Over $1.2M in new revenue to hospitals each year

Senator Stegner asked for more information on the relationship between **Mr. Packingham's** business and Access Health. **Mr. Packingham** explained that the Muskegon Community Health Project was the grant recipient that created Access Health as a separate nonprofit entity. This was originally done as a type of firewall because they were going to create a type of HMO. The two organizations were separated and given crossover board representation. After a few years, requests started coming in from all over the country for information on the plan. This was a problem because the mission of the nonprofits is tied to the county. They set up Community Health Ventures as a third entity to go out and answer the calls for information. He said this had to be set up as a for-profit entity even though they have not ever made a profit.

Senator Stegner asked about the relationship with small businesses themselves. He said he assumes the members are the employees and asked what requirements exist in allowing small

business to participate. He asked whether they actually make contributions and who decides who can join.

Mr. Packingham explained that there is an eligibility criteria for both employers and employees. He said that business eligibility requires they be uninsured for 12 months. He said they operate on a degree of trust but the business does sign a statement stating they do not have coverage and if that is found to be not true, the business will be banned forever. He noted that they have had to do this. To be eligible, the business must be located within the county and meet a loose definition of small business and be headquartered in the county. The business owner is required to pay a matching share for each employee. Business owners decide whether to offer the program to children or families.

Senator Stegner asked, regarding whether legislation may be required for authorization of this program, what restrictions are currently in place; either insurance related or public/private partnerships with municipal governments. **Mr. McMaster** said their major concern is in the insurance law arena. He said after meeting with members of the Idaho Department of Insurance, it has been stated that there is no place in the Idaho insurance code for this type of program. On the other hand there needs to be regulatory oversight and that should probably be with the Department of Insurance. He said if this is feasible, they would like to do a pilot project with some oversight.

In response to a question from **Representative Henbest, Mr. Packingham** explained that these services are only delivered in the county. He said this plan does not compete with commercial health care coverage, they fill a gap that is very necessary. He said the goal is to fill a gap that commercial coverage cannot. The hope is that businesses will migrate out of Access Health coverage to commercial coverage.

Representative Henbest asked whether someone with two part-time jobs could get employer matches from both jobs. **Mr. Packingham** said that question had not been asked in their community.

Representative Henbest asked about the relationship with Medicaid. **Mr. Packingham** said this does not require administrative or regulatory changes within the existing Medicaid delivery system. He said it required a letter of agreement on how they would cooperate and the roles of responsibility.

Senator Werk asked how they ensure that there are enough resources to cover people in the plan. He asked whether there is any reserve requirement. **Mr. Packingham** explained that since this program was not regulated by the insurance industry because it was created on the county level, the cash reserve as well as other requirements were not necessary. He explained that this is a collaborative agreement that is based on the fact that the current system uses hospitals as cash reserve for risk through uncompensated care and counties are responsible for indigent care. In developing this hybrid plan, they began the program and as it grows slowly, they have the ability

to set some aside. As time went by, they had enough to buy their own building and have gained a revenue stream. He said they have in effect created a $500,000 reserve mainly for cash flow. For big risks, they meet with hospitals and ask hospitals if they will take part of it. He said hospitals do take part of the risk because it is in their interest to keep this organization or plan going. Hospitals are getting 2/3 of all of the medical claims that go through there. **Mr. Packingham** said this plan actually spreads the risk instead of bundling it into cash through agreements with other providers and so on. He said they do run audits and actuaries on themselves.

Senator Werk clarified that each partner that provides care for the plan partakes in the overall risk pool and they understand this. **Mr. Packingham** said yes. He explained that these people will still get medical care and with Access Health in the picture, providers at least have some sort of payment.

The next meeting was scheduled for December 13 at 8:30 a.m.

This meeting was adjourned at 12:40 p.m.