MINUTES
(Subject to Approval of the Task Force)

HEALTH CARE TASK FORCE

November 24, 2008
Boise, Idaho

Cochairman Dean Cameron called the meeting to order at 9:08 a.m. on Monday, November 24, 2008. Members present were Senators: Dean Cameron, Joe Stegner, John Goedde, Patti Anne Lodge, John McGee and Elliot Werk and Representatives: Cochairman Gary Collins, Sharon Block, Jim Marriott, Carlos Bilbao, Margaret Henbest and John Rusche. Absent and excused were Senator Tim Corder and Representative Fred Wood. Legislative Services staff present were Paige Alan Parker, Amy Castro and Twyla Melton.

Others present were: Woody Richards, Doug Dammrose and Julie Taylor, BlueCross of Idaho; Tim Olson, Regence Blue Shield; Joie McGarvin, America's Health Insurance Plans; Jim Stark, Idaho Education Association; Kathie Garrett, Association of Development Disability Agency; Kurt Stanbridge, Glaxo SmithKline; Heidi Low, American Cancer Society, Stephen Thomas, Idaho Association of Health Plans; Kris Ellis, Benton & Associates; Molly Steckel, Idaho Medical Association/Idaho Psychological Association; Tom Shores, Health Underwriters; Mark Browning, State Board of Education; Mel Wiseman, Shoshone School District 312; Mike Friend, Idaho School District Council; Corey Gurber, Saint Alphonsus; Brian Duncan and Karen Echeverria, Idaho School Board Association; Reed Murdoch, Wyeth Pharmaceuticals; Amy Holly Priest, Business Psychology Associates; Cliff Hart, American Falls School District, Idaho Association of School Administators; Representative Phylis King; Leslie Clements and Chris Bauwens, Department of Health & Welfare; Bill Deal, Department of Insurance; Wayne Davis, Idaho Association of School Administrators; Suzanne Budge, SBS Associates, National Federation of Independent Business; Ladonna Larsen, Idaho Health Data Exchange; Benjamin Davenport, Evans Keane; Dona Van Trease, Idaho Public Employees Association; Cynthia Ness and Teresa Luna, Department of Administration; Joyce McRoberts, Governor's Office; Bret Noble, Idaho Community Action Network; Phil Hardy, Communications, Senate Majority Caucus; McKinsey Miller, Gallatin PA; Colleen LaMay, Idaho Statesman; James Fletcher, Idaho State University; Laren Walker, High Risk Pool Administrator; Dr. Kurt Seppi, Physicians Composition Center; John Key, Gary Fletcher and Debbie Tylor, St. Lukes; and John Marren, Attorney, Hogan Marren Ltd.

NOTE: All copies of presentations, reference materials, and handouts will be on file at the Legislative Services Office (LSO).

Cochairman Cameron introduced the first speakers, Mark Browning, State Board of Education, to provide an update on public post-secondary student health care plans.

Mr. Browning distributed a status report prepared by **James Fletcher**, Idaho State University, regarding the Consolidated Student Health Insurance Program (SHIP) (on file at LSO). A group of financial people from Idaho State University (ISU), Boise State University (BSU), Lewis and Clark

State College (LCSC) and the Department of Purchasing have been working on the student health insurance issue in anticipation of having one provider. The University of Idaho (UOI) has opted to remain with its current program. Best Value Procurement will allow those participating institutions to receive bids and tailor the plan to meet requirements of the institutions. The Request for Proposals is currently being crafted and it is hoped that a contract will be finalized by February, 2010.

Cochairman Cameron asked if the universities profit from the sale of the product to the student. **Mr. Browning** stated, to his knowledge, they do not; he will double check that and get back.

Cochairman Cameron wondered why some institutions do not allow students to stay on their parent's plan when certain threshold deductibles are not met, even though the institution's overall insurance product is inferior to the parent's. **Cochairman Cameron** questioned the practice of using the deductible as the sole criteria as being contrary to legislative intent and asked **Mr. Browning** to investigate and get back to the Committee. **Mr. Browning** agreed that the deductible shouldn't be the sole sorting criteria. **Senator Werk** suggested that the State Board look at the policy and determine what constitutes a proof of health insurance and what is the threshold.

Cochairman Cameron stated that the Task Force would like to see all four schools working together and noted that there has been some consideration given to legislation requiring that. However, it would be much better if the universities and the State Board do it on their own. **Cochairman Cameron** asked what **Mr Browning** needed from this Task Force on that point. **Mr. Browning** responded that he will remind the subcommittee of the will of this Task Force. **Cochairman Cameron** added that the desire of the Task Force is that the request for proposal would have a uniform choice of products from which students could choose and one single carrier. **Mr. Browning** confirmed that is the idea behind this, to buy in bulk, gaining an economy of scale.

Senator Goedde commented that the deductible is easy to compare, but comparing plans may be asking for trouble. **Cochairman Cameron** agreed that it was difficult to compare plans and maybe, if they are on their parent's plan, they should be allowed to stay on the parent's plan as long as they can prove they have coverage. **Senator Goedde** suggested setting up an appeal process.

Representative Bilbao asked why the two-year colleges are not included in the effort to develop a common student insurance plan. **Mr. Browning** answered that the community colleges have their own taxing districts and their own governing boards, are subject to the policies of those boards and fall under the State Board only in the area of academics.

Representative Rusche inquired if that meant the community colleges do not have the same insurance coverage requirements and asked whether those requirements vary between full-time and part-time students. **Mr. Browning** said the specific insurance requirements vary between schools, but the general requirement is that the students have health insurance. The genesis behind requiring students to have insurance coverage was that students were underinsured or not insured and the county indigent funds were being taxed by students with high health care costs.

Cochairman Cameron asked if that State Board insurance requirement also applied to community

colleges as well. **Mr Browning** agreed that it does, but the community college individual Boards of Trustees can define exactly what that health care coverage is.

Representative Block asked if it would be possible for those community colleges to choose to participate with the universities in the common insurance carrier plan. **Mr. Browning** replied that was a reasonable proposition and would take it back to the subcommittee. He said that an expanded buying base increases buying power.

Cochairman Cameron thanked **Mr. Browning**, **Mr. Fletcher** and their subcommittee for their efforts and progress.

Senator Stegner reported on the status of the mental health transformation project, stating that there has not been much change since the last meeting. The Mental Health Subcommittee is waiting for some indication from the Governor's Office about the Western Interstate Conference on Higher Education (WICHE) proposal. There have been briefings with the Governor's representatives and staff who have expressed interest and basic support of the WICHE proposals.

Representative Block said the subcommittee is anxious to hear from the Governor's Office and is looking forward to working with all parties to make some decisions on this issue.

Leslie Clements, Department of Health and Welfare, Medicaid Division gave an update on CHIP-B and ACCESS card programs. (Ms. Clements' handout is on file at LSO.) **Ms. Clements** said that accomplishments in the last year included outreach, updating brochures and assisting with the training of 30 new health care assistants. The Department presented the Legislature with results of a study by Milliman Consultants and **Ed Baker** at Boise State University on what other states are doing with premium assistance programs. These consultants worked closely with the Division of Welfare in the area of Medicaid eligibility. The length of the time period to process the application has been shortened for children's coverage under Medicaid and the premium assistance program. Participants in the Women, Infants and Children (WIC) program not covered by Medicaid were targeted, resulting in 34 applicants. The Department has a small contract with Mountain States to identify the barriers to families who are presumably eligible for WIC but are not taking advantage of this program as well as other direct coverages. Enrollment has remained constant.

Ms. Clemens reiterated that a key date is April 2009, when Congress will be asked to reauthorize the Children's Health Insurance Program (CHIP) which is federally funded through Title XXI and provides the match for this premium assistant product, as well as for other direct coverages. Right now, Idaho is spending up to it's allotted budget for this program. The big question is whether the adults on the premium assistance program will continue to be covered since adults are not covered under Title XXI. Consideration is being given to moving adult funding to Title XIX which provides greater flexibility for inclusion of adults through small business insurance assistance programs. However, changes to Title XIX must be budget neutral.

Pages 3-4 of the handout gives some premium assistance options to be considered. The study shows that other states have utilized Title XIX funds to open their programs to employers with 50 or more employees, increasing participation. Methods of marketing the availability of these programs

need to be developed. It would also be beneficial to allow Employee Retirement Income Security Act (ERISA) plans to participate. There is also ample opportunity to reduce the complexity of administration. One way to do this would be to remove the burden from the employer by making payments directly to the employee participants who would, in turn, be responsible to take the subsidy to the employer. There is ample opportunity to consider these options since the current waiver ends in November 2009.

Cochairman Cameron asked whether the entire premium assistance program would be moved from Title XXI to Title XIX or only the adult piece. **Ms. Clements** said a blended Title XIX and Title XXI fund mechanism is being considered. This is an important policy decision that needs to be made up front. The tradeoff is that Title XXI funding is matched at 80% while Title XIX is matched at 70%. If it was the desire of the Task Force and other stakeholders, it could all be funded under Title XIX.

Representative Henbest asked if moving the premium assistance program to Title XIX would expand eligibility to adults in terms of incomes at 150% or 175% of the federal poverty level, and whether the federal government would allow a narrowly crafted plan for a small business and employees with limited incomes. **Ms. Clements** responded that could be addressed through the waiver process.

Representative Bilbao questioned whether the program could really be expanded in light of the diminishing state revenues and asked whether Idaho is being required to expand the program. **Ms. Clements** stated that in light of what revenue forecasts, it is difficult to talk about expansion. Health care has to be looked at from the state perspective of the entire health system, not just individual segments. More and more people are uninsured and unable to get insurance. It is important to look at what the public should be doing, how it can contribute, and what populations should be addressed. In Idaho, it should be about the safety net when there isn't a private sector answer to the problem.

Cochairman Cameron recalled that the state portion of CHIP is currently funded with insurance premium tax dollars and there are about $8.0 million of unmatched premium tax dollars. If those premium tax dollars were matched on an 80/20 basis under Title XXI, some expansion could be done without affecting the General Fund or the taxpayer. It does affect the federal side because every enrollee would be paid at 80% by federal dollars and the federal government is in as much trouble as Idaho.

Senator Goedde asked whether the Milliman modifications #1 (offer premium assistance coverage for employer sponsored insurance regardless of business size) and #2 (use Title XIX funding to allow insured individuals to get help with premium assistance) had been considered in Modification #3 (coordinate marketing to broaden awareness of premium assistance programs). **Ms. Clements** replied that Milliman had not provided a fiscal impact for marketing. The Milliman study tried to determine what could be done differently. The whole marketing piece is something added on along with Modification #4 on the ERISA plans and Modification #5 on making payments directly to the participants. Milliman did not provide an impact in those three areas. **Senator Goedde** expressed concern that if this was actively marketed and the program expanded, the numbers projected may be

a lot bigger.

Cochairman Cameron said in the past the Legislature has been apprehensive about marketing, particularly for CHIPS and for Medicaid. This is a dilemma for the Department and requires a decision by this Task Force. People are not aware of the program and do not participate, but the purpose of insuring children and taking people off indigence rolls is not being met.

Ms. Clements stated that this program was introduced in a fiscally limited environment similar to the one we face today. She said there was concern about participation and an error may have been made on the conservative side; however, there are the premium tax revenues that are just sitting untapped that are intended to help resolve some of the uninsured problem. She said the goal is to use those funds we already have.

Senator Goedde proposed that one of the recommendations from this Task Force might be to suggest that the Department of Insurance include awareness of these programs in the law portion of insurance agent training so the agents would be exposed to what is available.

Cochairman Cameron noted that it is more difficult in getting on the ACCESS card than on CHIPS-B and asked whether the Department is looking at ways to make it easier to participate in the ACCESS program. **Ms. Clements** answered that the Department is looking at all administrative barriers and has streamlined the application process.

Cochairman Cameron suggested increasing the $100/child/month premium assistance, noting that some states have done so and have seen dramatic improvements. **Ms. Clements** agreed that is another area to be looked at in terms of incentives.

Representative Rusche looked at the potential eligibles for the various modifications (Milliman report) and wondered if that could be controlled by a number limit with a waiting list. **Ms. Clements** responded the limitation could be amended in order to provide control and prevent "opening the flood gates ." **Representative Rusche** said he lives next to Washington state which has a limit and a waiting list to control the risk.

Cochairman Cameron commented that agents and could market the program to those businesses who did not have coverage and, once the business prospers and the employees no longer qualify, the employer could provide its own coverage in order to retain good employees.

Senator Stegner asked what the Task Force should do now since a delay may frustrate efforts to renegotiate the waiver. **Ms. Clements** stated that the Department needs legislative guidance and at-the-table participation. **Cochairman Cameron** agreed and commented that there have been discussions with **Ms. McRoberts** and the Governor's Task Force on some of these changes and the Task Force will want to coordinate with them. There should be a package forthcoming from the Governor's Office which could be addressed at the next Task Force meeting.

Cochairman Cameron thanked **Ms. Clements** for her presentation.

Laren Walker, High Risk Pool Administrator, provided an update on the High Risk Pool. **Mr. Walker** reported that he had the opportunity to go to a meeting of all the high risk programs around the country and came away feeling very positive about Idaho's program and the interest in it by other states. Idaho is still very unique in using the private sector as a component of a High Risk Pool program.

Financial statements and a report from Milliman (on file at LSO) were distributed. There is about $24 million in this program; an investment policy was established, returning approximately two percent. Nineteen million is in government bonds, three million in money market funds, and the rest in certificates of deposits.

Milliman was instructed to do a study of the carriers, which are an integral part of the program, to determine the discounts they are receiving. Chart 2 in the report shows the discount percentage by type of service with a total of 21% in discounts which is considered very healthy and competitive. **Mr. Walker** concluded that the private component is doing very well.

Senator Werk, noting that the out-of-pocket portion for prescription drugs was 57% of the cost, asked, given that high out-of-pocket expense, would the person insured in the High Risk Pool be eligible for any of the pharmaceutical industry discounts or does the way the High Risk Pool contracts provide lower prescription prices. **Mr. Walker** agreed that it was high and that the plan design does have high out-of-pockets, but these are high risk people who otherwise would not have any insurance because of that status. There have been conversations with the Board related to those. Those people can still use the options available to the general population, if they opt not to run that particular drug or service through the plan.

Cochairman Cameron reminded everyone that not all of the High Risk Pool people are low income. The pharmaceuticals generally have an income threshold. There are a variety of choices within the plans. One of the most popular products is the health savings account (HSA), which has been growing the fastest of all the high-risk products. The goal is to strike a balance between being affordable and retaining the coverage.

Representative Marriott asked who is a high-risk person. **Mr. Walker** explained thresholds that are set. If the prospective applicant is rated at 150% above the street rate established by the carrier, then he or she has the option of acquiring one of these products. **Cochairman Cameron** further explained that the person is given the option depending on the person's health condition. If the person is in poor health, the carrier may opt to only offer the high-risk program. In Idaho, a person cannot be denied coverage, but can be limited to the high-risk products.

Representative Marriott asked if there were any figures on what the average high-risk person pays out-of-pocket for coverage. **Mr. Walker** stated that he had not seen the numbers, only the percentages, but he could get those numbers. **Cochairman Cameron** said that there are numbers in the handout tied to the conditions that are being treated. Averages are hard because there are some individuals that are intensive and some are not.

Mr. Walker discussed the financial information about the high-risk plan. The expectation is that

the plan will pay $8 million in claims for the calendar year 2008. The premium tax dollars going to the plan have resulted in a surplus but that is being reduced each year. At some juncture, the increased high-risk population would draw on the funds in reserve. The full report shows the breakdown by different programs, by carrier and utilization. At this time, 1,393 people are using high-risk products.

Representative Rusche referred to the ceded claims, asking what the "yes" and "no" meant. **Mr. Walker** said that some were ceded at the beginning of 2008, as the claims were coming in, but now are closed. **Representative Rusche** commented that the carriers do not make this decision on a month-by-month basis but when policy determines. During the duration of the contract, while premiums are paid, the policy is in force. **Mr. Walker** concurred. **Cochairman Cameron** clarified that the people who are no longer ceded are deceased or obtained coverage from somewhere else.

Representative Henbest expressed concerned that the 30% out-of-pocket cost plus the premium most likely exceeds the national $12,000/yr average for health care costs. **Mr. Walker** stated that there are out-of-pocket maximums, but they are fairly high. **Representative Henbest** commented about a possible state subsidy to assist with premiums, pharmaceutical and out-of-pockets to make it more affordable. **Mr. Walker** added that the federal government had some grants that have been accessed by the High Risk Pool. There is a supplemental grant that some states are using for premium subsidies. The High Risk Pool board is looking at potentially trying to do something in this area.

Representative Rusche asked whether the counties and the Catastrophic Health Care Cost Program are participating with the High Risk Pool to mitigate cost. **Mr. Walker** replied that the High Risk Pool has not seen that. Those people who do not have High Risk Pool coverage will probably go to the indigent program.

Cochairman Cameron interjected that the counties have helped individuals obtain coverage. The price of the High Risk Pool products are not bad compared to other private sector products. The Board goes to great lengths to have actuarial studies on where the premium should be based on each product and then subsidizes that rate by using the premium tax dollars. The subsidy is internal, not external, and so it is not seen by the customer. Last year legislation was passed to allow those who have maxed out their coverage to come into the High Risk Pool

Mr. Walker concluded his report noting that the composite rate will increase by 7.7% for the coming year.

Cochairman Cameron introduced the next series of reports on health insurance costs and how it is affecting schools, teachers and school districts. He noted that the rate increases were not as difficult this last year but are still tough on school districts.

Jim Stark, Idaho Education Association, provided the Task Force with teachers' perspectives on public school health care issues. **Mr. Stark** distributed a summary of insurance issues for Idaho schools (on file at LSO) and focused his comments on the current coverages and the potential risk for those insured through the schools. Some people have illusional insurance; they pay a premium

and have insurance but their individual risk can be as much as $10,000/year for a full time employee who makes $15,000/year; that is not insurance. **Mr. Stark** views health insurance as a number issue. The plans offered to schools are consumer-based, but there is no shopping for coverage in rural Idaho. One plan will not meet all the needs for all the schools. Boise is much different than Challis, where Mr. Stark grew up, which is 60 miles from the nearest doctor.

Mr. Stark said when he goes to a school, he looks at its insurance program and the employees' understanding of the program. Employees don't necessarily know what a stop loss is, may know what the copay is on prescription drugs and for doctors, but do not understand hospital copays. All that information is needed to determine personal risk for the employee. By making these determinations, he can explain what the employee is getting for the premium dollar. All school districts struggle with the compensation dilemma, whether to compensate employees through salary or through benefits. Some schools are giving up on compensating through insurance coverage in order to have enough salary to attract teachers. Schools are perceived to have good or better coverage as those in the community around them.

There are a lot of questions and misunderstandings about the state insurance plan. One misconception is that there is too close an alignment between the state and BlueCross of Idaho. **Mr. Stark** has been able to go back to the schools and inform them that the BlueCross provides a good, competitive plan. The schools don't feel they have sufficient decision-making information. They don't get adequate reports or cost ratios and are faced every year with making decisions about plan design and premiums without knowing until the end of April what the premium increase will be. They can't budget responsibly for a premium rate increase.

Senator Goedde stated that insurance committees and school districts are made up largely of older employee/retirees and that benefits tend to be tailored to address their needs rather than those of young families. **Mr. Stark** replied that insurance committees are usually made up of a business manager or superintendent from the central office, teachers and maybe a retiree. The perception is accurate; the teachers on the committee tend to be older and value insurance. Younger teachers generally do not have the interest.

Representative Rusche asked if there were any recommendations that could be made. **Mr. Stark** said he would encourage the schools to somehow avoid the high-risk insurance programs since employees, like cooks and maintenance people, cannot afford the risks. **Representative Rusche** asked whether, because of plan design, only those who absolutely have to have insurance are enrolling but are not enrolling their families. **Mr. Stark** agreed that was true.

Representative Block asked whether consolidating the school districts into a pool has been discussed. **Mr. Stark** explained that consolidation should be a good deal for everyone, the bigger pool, the better the buying power. However, if that were true, why aren't the larger schools in the state pool. The answer is that the bigger schools probably have a better deal elsewhere so the only ones in the state pool are those who can't get something better on their own.

Representative Marriott asked what the state can do to provide information on the plan design. **Mr. Stark** answered that schools need inexpensive educational resources. The people who are now

providing those explanations could have a conflict of interest. They need objective information that helps them make wise decisions on how to construct their plans and use their money wisely.

Representative Henbest asked **Mr. Stark** for his thoughts on a mandatory state fund to reduce adverse selection issues **Mr. Stark** said the superintendents would be delighted to turn this over to someone else; they don't want to manage it or take the criticism for it. There is a need for a statewide plan but there would have to be the confidence that the plan was well managed, was using the money wisely and met the individual needs. Right now, those perceptions are not there. There is no quick answer.

Cliff Hart, Director of Special Education, American Falls School District, stated that the needs of the special education segment of the schools should be discussed at another time. **Cochairman Cameron** agreed.

Mike Friend, Executive Director of Idaho School Districts Council, addressed the Task Force on the school districts' perspective on public school health care issues. **Mr. Friend** reviewed the five points discussed with the Task Force when he met with it last year:

1) Maintain quality health care coverage to all employees.
2) Extend coverage to uninsured through alternatives to the then current BlueCross of Idaho family coverage.
3) Provide for access to medical providers in the areas where the access isn't very good. Primarily, Valley County and the Twin Falls area.
4) Impact of premiums on school district budgets.
5) Impact of the master contract on the local school district level.

According to **Mr. Friend**, teachers' associations have started to open up dialogue with their local school boards about health care coverage. Among the current Council membership, 125 groups, 97 school districts, most of the charter schools and a few other qualified educational affiliates have insurance through BlueCross. That represents 18,250 employees with 36,000 family extensions that have operated with an administrative agreement with BlueCross of Idaho at a 91% target loss ratio. An agreement has been negotiated whereby if the premiums were greater that the claims paid, there would be refunds to districts. Those rebates have occurred for about six or seven years. Last year, the ratio was 91.95%; BlueCross suffers the loss for the first percent over 91 and the Council participates in the loss beyond that. The 18 month spread was 92.1% which cost the Council $55,000. The good side is that the program worked.

The health care study was completed to show what the school districts are dealing with as they manage their budgets and design benefit programs for employees. To address some of the findings of that study, an out-of-state actuary was retained. This helped the Council to provide options to the school districts. First, the Council needed to choose whether it functioned as an endorser, an active manager or a self funded group. The Council had served as an endorser of BlueCross products. The Council Board moved to an active management role. BlueCross approached the Council with three options:

1) Basic catastrophic, high deductible, high out-of-pocket plan, with a target audience of those who had no ability to cover families. One hundred percent of the employees were covered, but salaries were not high enough for family coverage. This plan was offered in every district but only 150 employees opted for the basic plan and 350 total were covered. The Council still hopes to offer this high-risk plan.

2) A wellness program with a $500 first dollar benefit for preventative services and testing, plus $1,000 on colonoscopies.

3) Moved from the $25,000 cap, for purposes of pooling, to $50,000, so that the larger claims are spread across the pool of 125 members and changed to a $300 deductible. The renewals are tiered with 94 districts increasing 5.3%; 69 at 3.6%; and 31 at 2%. This methodology helps smooth out the peaks and valleys.

The Council addressed the pharmaceutical program which was about ten years behind the times. Several providers were called in to talk about the pros and cons of carving the pharmacy benefit out of the current program. Rating methodology was another point highlighted in the study. Three years of claims are used to determine which tier is appropriate. That is not a BlueCross problem, but a Council problem that is being addressed.

There are many options as districts design the insurance program they want, but choice costs money. In the future, there may be a limited number of options offered. The Council is also looking at employee assistance programs and the mental health parity included in the federal bailout plan. The current mental health benefit is minimal and not much used. The mental health provider community isn't very large. Thus, psychotropic medications are being prescribed by general practitioners so the data does not reflect the true cost of mental health. Then there is the self-funded alternative. If pharmacy is carved out, it would be self-funded.

Talks will continue during renewal meetings. The study commissioned by the Council is ongoing. The goal is to provide quality health care that is affordable. The Council must be creative in order to provide local school districts with viable option to balance rate increases, demands of local constituents, employees and health care options.

Representative Henbest asked about the costs the Council incurs to help the school districts manage their insurance plans and about the administrative fee that BlueCross charges as a percent of the premium. **Mr. Friend** said the Council has a per member/per contract agreement with BlueCross that brings in about $125,000, and the Council does other activities to generate money for Council activities. The original study cost $1.25/member and the actuarial consultant will cost about $35,000/year; the administrative cost is the 91%. **Representative Henbest** thought it odd that local control is discussed but the state does most of the funding, wondering why should local control drive the issue. **Mr. Friend** stated it is a local issue when talking about deductibles but that major changes must be done at the state level to reach a balance. The Council, school districts and the state must continue to look at all issues.

Representative Rusche asked what percent of the eligibles, including spouses and dependents,

opted out of coverage. **Mr. Friend** responded in one district, all the employees opted out. He couldn't answer about spouses because it is unknown how many people are covered elsewhere.

Cochairman Cameron commented that the Task Force appreciated the progress that has been made even though it may not have been quite as far as they had hoped, but it is progress and the Task Force appreciates the hard work.

Brian Duncan, Chairman of Minidoka School Board and President of the Idaho School Boards Association, addressed the Task Force on the school board perspective on public school health care issues. **Mr. Duncan** noted that a lot of the perspectives have already been addressed. Most of the districts across the state have seen premiums, over the last ten years, jump from $190/month to almost $400/month. In Minidoka, the annual premium is about 10% of the annual budget. The district budget runs about 80-85 percent in salaries and benefits so a change in the health care premium has a large impact on the budget. Many times, negotiations hinge around those premiums, and they have to wait for that number so it can be put before the insurance committee. Typically, the school district is asked to assume any increase in the health benefits and must find money for that somewhere. Basically, the school districts take money from other parts of the budget to cover the costs by reducing staff and limiting salary increases. The Insurance Committee has done a good job limiting increases, but there are still problems with increasing deductibles and copays while maintaining the same level of coverage. They have an active wellness program, but most of the cost reduction data on this program is anecdotal.

Cochairman Cameron thanked **Mr. Duncan** and turned the chair over to **Representative Collins** for the duration of the meeting.

Dr. Kurt Seppi, President and Managing Partner, Physicians Composition Center, **Debbie Tyler**, Executive Director Physicians Services, St. Lukes Regional Medical Center, Twin Falls, and **John Marren**, Attorney, Hogan Marren Ltd, Chicago, IL, addressed the Task Force on clinical integration and electronic medical records in the Magic Valley.

Mr. Marren explained that clinical integration is a legal term but it really is a response to the five minute system in health care we have today. The idea is to buy value, integrate and measure quality, provide data and use proper incentives. This is a consistent Federal Trade Commission (FTC) definition of clinical integration. The FTC is involved because physicians are coming together to reduce the cost and improve the quality of care. In so doing, physicians are seeking to collectively negotiate in the fee-for-service environment. The FTC takes the position that this is a per se violation of the law but, if the physicians are clinically integrated, this is permissible. The idea of clinical integration was brought forward in 1996 by the Department of Justice and the FTC. Many lawful, well-constructed clinical integration programs are in place across the country. The results of these programs are contained in *The 2008 Value Report*. Using 2007 clinical integration data, millions of dollars have been saved.

The issue is changing the culture of reimbursement and changing the culture of medicine. The FTC knows that higher prices are going to be negotiated collectively, but if the cost is driven downwards because of the reduction in the use of resources and by eliminating unnecessary services, the minimal

increase in the unit price is justified financially by the reduction in cost. The program has to be real and involves educating doctors, training them or "kicking them out" if they aren't following the plan. Clinical integration is the creation of a network of physicians working together, coming up with new and better ways to provide care. Anyone buying health care services should work with people who are organized in this way.

Dr. Seppi (copy of presentation on file at LSO) brought the clinical integration idea to the community level in Magic Valley. A quote from the Journal of American Medical Association stated that "Today's preoccupation with cost shifting and cost reduction undermines physicians and patients. Instead, health care reform must focus on improving health and health care value for patients . . . Improving the value of health care is something only medical teams can do . . . Physicians can lead this change and return the practice of medicine to its appropriate focus: enabling health and effective care." Physicians have to be in the middle of this. **Dr. Seppi's** PowerPoint presentation addressed the decline in health care on a national level.

The activities in Magic Valley are centered around clinical integration, allowing independent physicians with small group practices to work with inpatient health care systems in a collaborative effort. It requires the facilitation and coordination of patient care across physicians, providers, settings and time in order to achieve care that is safe, timely, effective, efficient, equitable and patient focused. The need is to promote change in provider culture, redesign payment methods and incentives and modernize federal laws. **Dr. Seppi** explained the differences between the old system and the new system. There must be an aura of trust, trust between providers, trust between providers and hospitals, and trust between providers and other stakeholders like third party payers, government and employers. These integrated relationships must be developed locally.

Dr. Seppi stated that the goal is to open the lines of communication with all stakeholders, including government leaders, so they can better understand the state's problems and challenges with the health care systems and can respond to that as necessary.

Dr. Seppi outlined the core objectives of the electronic medical record system as:

1) A seamless flow of health information across all care settings.
2) The ability to track patient and provider outcomes across the health care system.
3) Promote and facilitate collaboration between all practitioners and parties involved with care delivery.
4) Involve the patient and their care management through portals and/or secure information exchange.

Ms. Tyler demonstrated the problems involved in a paper record system, using the example of helping her mother traverse the health care system. This experience showed how broken the health care system is and the dire need for change. The information contained in the various files and the number of providers made it impossible to have one complete list of services, pharmaceuticals and diagnosis. **Dr. Seppi** added that while the practitioner who compiled the primary file did a good job, 80% of the physicians still keep paper medical records in an unsystematic way.

Senator Werk commented that the primary physician who compiled the paper chart will be the only one that sees it and that nobody else will have ready access to it.

Dr. Seppi stated that the electronic medical record is the cornerstone of the integration program. Without an integrated approach, little benefit will be gained over the present system because the information remains in inaccessible silos. Appropriate information must be seen by the appropriate provider at the appropriate level. The development of the system in Magic Valley began in 2002 by establishing a vision and the start of the planning process. The year 2004 saw a collaborative effort between CSI, Magic Valley Regional Medical Center and community physicians resulting in a grant from the Agency for Healthcare Research and Quality to continue with the development of the program. Implementation began in 2005 and by the end of 2008, there will be 70 health care providers on the electronic medical records system. All participants will be using one chart for each patient on a shared system.

Dr. Seppi demonstrated how the electronic medical record system (EMR) works in comparison to paper charts. Various aspects of the EMR applied to certain National Patient Safety Goals. Each chart is specific to the patient with individual patient data from date of birth. It contains the complete medical record of the patient, including symptoms, diagnosis, physician notes and a complete medication list. The chart also has a built-in safety factor that indicates if there is the potential for a drug interaction or an allergy reaction. Templates are being developed to provide information on patient care, like diabetes, where the patient can then become involved in controlling the health issue. This is relative to evidence-based medicine. Another advantage is improved efficiencies because the EMR charts will show when tests were done so providers will not need to repeat the tests.

A final point is transparency. It is strongly recommended that "transparency initiatives" be supported to give practitioners the information to improve the quality of care, reduce costs and empower consumers to make value-driven choices. This is not an overnight process; it takes time, leadership and collaboration among all the stakeholders.

Representative Marriott congratulated **Dr. Seppi** for an excellent program and asked whether consideration has been given to making a smart card available to patients. **Dr. Seppi** said that has been discussed and is a great idea. For more accuracy, it would be better to generate the patient report card each time the patient comes in.

Senator Goedde asked if there is a statewide initiative working towards an EMR. **Dr. Seppi** agreed there was. **Representative Rusche** said there is an initiative for health data exchange that would treat Dr. Seppi's organization as a medical practice and allow it to exchange information held in that practice with other practices and practitioners. Standardized medical records could be transported and presented in the same medical record format. The secret is standardization and to move that information from one site to another. **Dr. Seppi** commented that his group supports anything that will help improve patient care and transparency of medications.

Representative Henbest inquired about the $1.3 million paid for everything and noted that it is an expensive endeavor although it also saves money. **Dr. Seppi** said the $1.3 million was seed money

but right now in hard cost, about $3.6 million has been spent. Learning the process takes a long time since it represents a different way of thinking. An integrated approach with insurance companies, governments, employers and all stakeholders is necessary. It is something that will save the health care system, but it cannot be done cheaply.

Representative Henbest commented that her primary health care provider went to EMRs about six months ago and they worked 12 hour days for six months to transfer the paper records to electronic. When she made a request for an immunization record recently, she had it within five minutes. That would never have happened with paper records.

Representative Rusche stated that back in the 1980-1990 period there was a push to capitate paid systems on a per-patient basis and let providers use their own efficiencies to develop profit. **Representative Rusche** wondered if a payer such as Medicaid or BlueCross could pay $250 per diabetic patient per month to allow the system to develop. **Dr. Seppi** responded that his integrated practice is not looking to capitate or money for increased reimbursement. The goal is to practice medicine and try to find ways to make sure the appropriate care is given.

Mr. Marren interjected that the problem with capitation is that the people who are providing the care end up underpaying for care. Ultimately, people will recognize that this is a different arrangement and provide reimbursement that recognizes the value and helps fund some of the initiatives while reducing the cost of care.

Representative Marriott asked if this is a turnkey system. **Dr. Seppi** answered that the product can be purchased but the relationships cannot be bought. That is why the emphasis should be on a group of physicians that are committed to work with the project and the patients. To put the system together, there must be physician support and hospital support. Physicians are willing to look at clinical relationships that actually improve care and then use EMR as a tool to get there.

Cochairman Collins thanked **Dr. Seppi** for all the work he has dedicated to this system.

Teresa Luna, Communications Manager, Department of Administration, addressed the Task Force on state employee and retiree health benefits, proposed changes and projections. **Ms. Luna** said the Department had spent a great deal of time over the last year talking about the retiree health care plan and benefits. The Department drafted and brought legislation to the Legislature last year, but it did not pass; similar legislation is planned for this year. Department representatives traveled the state explaining the legislative proposal and what it means to retirees if it passes and sought input. Thirty-three meetings were held and 1,300 out of 3,300 affected retirees attended. Additional meetings are being scheduled with other stakeholders to discuss this legislation and receive additional input.

This last fiscal year saw significant increases in premiums for active and retired employees. For the past two years, the state has funded premium increases out of excess medical reserves. Now that those reserves have been exhausted, the employees and retirees will have to fund those increases from their pockets. The state pays about 80% of active employee premiums, so the impact is minimal. However, retired employees pay 80% of the premium, representing an increase of anywhere from $84 to $309 per month. Premiums will continue to increase a standard 12-15 percent

per year based on trend.

A high deductible plan was instituted July, 2008, and 12 active employees moved from the PPO to that plan. This was expected because increases to the PPO have been small. From the meetings across the state, the Department representatives heard how the higher premiums are affecting retired employees. Consequently, effective December 1, 2008, a high deductible plan was made available to the retirees. The rates for this plan were about the same as the PPO rates were for 2007, but the plan has a much higher deductible. This high deductible plan is a viable option for state retirees who are healthy. The Department is also working on the wellness initiative for active employees. Employees, retirees and dependents have taken advantage of the smoking cessation benefit.

Representative Rusche asked if a PPO was available everywhere in the state. **Cynthia Ness,** Manager, Employee Benefits Office, responded that there is a PPO available around the state. However, particularly in the Twin Falls area, there aren't as many providers who chose to be in the PPO network.

Representative Rusche asked what the rates were for the traditional product. **Ms. Ness** explained those were the traditional rates and the PPO rates were a little bit lower. **Representative Rusche** stated a non-Medicare eligible retiree would pay $12,000/year for himself or herself and a spouse, for a product that has a $6,750 out-of-pocket stop loss, totaling $20,000 in health care coverage before any benefits are paid, and asked, "How many can afford to do that?" **Ms. Ness** replied that this is the same plan the active employees have. The situation heard in the meetings was that rates jumped to over $1200/month for a retiree and family which could not be afforded. This is the only alternative that can be offered, although it does not represent a good tradeoff for anyone who has health care needs or cannot afford the $2000 deductible. About 50 retirees have enrolled in that plan to date.

Representative Rusche inquired if there was concern or perception on the part of the Department as to what this means for employee morale. **Ms. Luna** answered that the PPO is the plan that has been in place for active and retired employees for many years. The difference that was seen this year was the high increase in premiums. The high deductible plan, at this point, is the best effort for this timeframe to reduce the premiums and provide time to address the rates.

Senator Goedde reaffirmed that there was no benefit paid until after $6,700 plus the monthly premium was paid. There is coverage available at the individual deductible after the 80%. **Ms. Luna** said that the retiree would pay the premium plus $6,700 as the out-of-pocket maximum, but will still get benefits before reaching the maximum. This is the same plan as the active employees have; the difference is the amount the state contributes toward the premium.

Senator Werk asked what the reception was when the Department held the 33 meetings. **Ms. Luna** responded that overall, the meetings went very well, regardless of whether the people agreed with the approach; they were appreciative that it was being presented to them. There were some meetings that were strained and some meetings where people seemed to understand the changes that were proposed. For some, the changes made sense; for others, they didn't. There was some resistance, but there was also understanding of how legislation affects them.

Senator Werk inquired if the justification for the retiree proposal has to do with an accounting liability since there has not been any indication of how much money the state would have to appropriate to cover the retirees. **Ms. Luna** replied that the liability does stay on the books, but this is the first year that bottom line had to be reported. Today, the state has an unfunded liability of $477 million. If this legislation does not pass, the Department will be asking for $35 million to try to offset that $477 million liability. During the first week of session, all legislators will be invited to a meeting where Milliman Inc. and some bond people will explain how this will affect the state and the enrollees.

Senator Werk has been bothered by the lack of an aggressive wellness plan and incentives for employees where, with a high deductible plan, credits could be used to pay down the deductibles. **Ms. Ness** answered that over the last several years there was discussion of non-smoking premium rates, but it did not materialize. There is a wellness allowance of $250/yr. in the traditional plan. The PPO plan has no limit to the number of wellness visits or treatment, only the $20 office visit copay. There are disease management programs and they are proactive in care and treatment. In CY2008 there were 59 participants in the weight management program. There are participants in the smoking cessation program. The Department has not incentivised or disincentivised those kinds of lifestyle changes.

Senator Goedde referred to **Senator Werk's** question about the liability and asked for the present value of the unfunded liability. **Ms. Luna** stated that the present value today is $477 million. **Senator Goedde** disagreed and said that included extended payments. **Ms. Luna** agreed. If this legislation were to pass, it would save about $5.1 million/year in annual payments. **Senator Goedde** requested that Milliman get the present value of the unfunded liability and provide that information to the Task Force.

Dr. Doug Dammrose, Senior Vice President and Chief Medical Officer for BlueCross of Idaho, discussed insurance company efforts to contain costs. (**Dr. Dammrose's** PowerPoint presentation is available at LSO.) **Dr. Dammrose** is aware of all the angst about the cost of health care and everyone in the room was concerned about the rising premiums. The objective is to mitigate that escalation of concern for health care costs. **Dr. Dammrose** explained what BlueCross is doing to have a healthier Idaho and reduce health care costs. He noted that, first and foremost, we are all stewards of the resources that are very precious and very expensive. We are all part of the problem and we must work together to fix the problem.

Dr. Dammrose provided a comparison between today's society and what should be happening in regards to health care. One problem, according to **Dr. Dammrose**, is health care supply generates demand. Identified as the problems were:

-Increasing cost and frequency of health care services drives the cost of health insurance.
-A system that is not affordable for many today will not work for everyone tomorrow, costs must be reined in.
-Employers struggle to compete due to health care costs and states struggle to balance the budget with other needs.
-Improvements will only occur if cost, efficiency and quality is addressed.

A Dartmouth study showed that the highest cost of care produced the lowest quality of care. Idaho falls into the upper one-third of that spectrum. **Dr. Dammrose** reviewed an Idaho commissioned study which showed a $1.6 billion increase in health care costs from 2000 to 2004 and identified the specific areas. Various studies have shown that waste is a big issue throughout the health care system. According to **Dr. Dammrose**, there are three areas of waste:

(1) Behavioral - individual unhealthy choices contributes 50% to the cost of health care, and yet only 4% is spent to modify those behaviors as projected by the Center on Disease Control.

Representative Rusche asked if there was any evidence that the wellness programs are effective. **Dr. Dammrose** responded that they are measuring the outcomes with pre and post tests and measuring kids and families knowledge about fruits and vegetables as part of the Color Me Healthy program for kids. **Representative Rusche** asked about evidence of that having an effect. **Dr. Dammrose** replied that it was to early to tell if the obesity index changed. This is the kind of specific target that needs to be addressed.

(2) Clinical - physicians and how patients are cared for.

There is potentially dangerous care being delivered that should be avoided. As **Dr. Seppi** mentioned, the Institute of Medicine has demonstrated probably 100,000 deaths annually occur from in-hospital errors. **Dr. Dammrose** is involved in case management and quality improvement programs and is currently engaged in four disease management programs: heart failure, diabetes, asthma and low back pain. His department measures outcomes using a large database with predictive modeling tools and data analysis, including internal and external referrals. For those state employees who participate in the diabetes self-management program, there are no copay requirements for related generic drugs, insulin and diabetes supplies. There is a member requirement to access the Personal Health Management monthly in order to log diabetes care data. To see if disease management was working, a 2005-2007 study using control groups showed that the disease management group costs were $200/member/year less than those without disease management and, when applied over the whole group, amounted to about $7.8 million, a significant impact.

Representative Rusche asked what the return was on investment. **Dr. Dammrose** said the return on investment was $2.50 to $1.00 spent.

Utilization management assures that care is done at the right place at the right time and uses evidence-based principles, transfers/alternative settings and optimal management of catastrophic cases. Various tools are used such as determination of medical necessity, BCBSA medical policies, member contracts, onsite medical directors, nurses and case management.

Undisciplined use of health care resources are driving health care costs. The best practice is to follow the guidelines and do the right thing. Overall, the savings allocated to total care management is $130 million; this is not a contractual adjustment, this is avoided cost. BlueCross collects and analyzes data and establishes measurements to track the results of these programs. A 2008 HEIDIS report showed that BlueCross rated positively against the National Medicare Advantage Median Rate in over one-half the categories. There has been improvement in hospital and emergency room

treatment through management of cases and collaboration between the physician, the hospital and the carrier.

(3) Operational - plan design.

That is the carrier end of the spectrum, processing claims better and faster and reducing the paper burden. BlueCross has tried to create a better value based benefit design such as waiving copays on a particular high cost illness like diabetes. The goal is to change the idea for more pay for more services and move toward a healthier population by paying for the right outcomes, not more services. Other operational efficiencies are provider contracting, medical management, pharmacy design/discounts, correct coding, COB, provider audits and paperless delivery. BlueCross' efforts provided a total savings of $442 million in 2007 that otherwise would be coming out as an added expenditure. BlueCross is actively looking for ways to reduce administrative waste by promoting health data exchange, excellent service, claims payment efficiencies and web based personal health management tools. BlueCross administrative costs in 2002 were 9.5% and in 2007 those administrative costs were down to 8.0%. BlueCross is trying to mitigate the cost, improve the quality of work and to do it with fewer resources.

"What is the Solution?"

- Focus on health outcomes instead of more services – we are broke, we can't afford more services. We can pay for efficiencies – getting more for less. We should be paying for outcomes so people who deliver proven, better health care get paid more.
- Design benefits/provide payment for services that are proven to work.
- Ensure plan incentives align with purchasers and serve the greatest number with limited dollars.
- Develop reimbursement relating to improved health, access, safety, quality and efficiency.
- Promote an efficient delivery system based on access to primary care.
- Use technology to coordinate care and reduce waste
- Share the cost and have coverage for everyone.

Representative Block asked for examples of what is being done to modify behaviors for substance abuse. **Dr. Dammrose** said that the health risk assessment should be identifying the use of alcohol and drugs. If there is a concern, online coaching and assistance is available. That is the wellness side. Case managers and vender associates facilitate the substance abuse and mental health cases. National mental health parity may go over the edge for costs if there is not a better way to manage treatment in more cost effective settings. **Representative Block** inquired if there were any kind of incentives in place to prevent abuse. **Dr. Dammrose** responded there were no incentives around substances particularly.

Senator Werk pointed out the wellness program and the aging workforce at the state level asked for suggestions. **Dr. Dammrose** stated that the limiting factor is individual choice. There are difficulties with engaging employees to create opportunities for incentives around wellness. There have been recommendations to the state regarding incentives. The question is how much real dollar incentives can be afforded.

Representative Rusche asked what BlueCross or other payers are doing in relation to medical home and primary care and whether are we still in the industry paying augmented rate for procedural services as opposed to contract services? **Dr. Dammrose** said that in terms of physicians supply and ways to manage that, the question is do we need more manpower, or do we need to use the manpower more efficiently. Yes we need to replace aging primary care physicians but a wholesale desire to flood the community with physicians will only cost more money without solving the problem. The best model would be collaborative care and case management. As long as there is the mentality that money drives where people go, the system will be broken.

Representative Henbest referred back to the 2002 and 2007 premium dollar allocation charts for professional services, noting that the percentages rose for hospitals and prescription drugs and asked what BlueCross is doing to control those costs given that there is a lot of technology and added services at hospitals. **Dr. Dammrose** referred to the Dartmouth article that identified the use of these services in the acute care setting, such as emergency rooms where there is no preauthorization, has driven costs out of sight. The models in place at Mayo Clinic and the Giesinger Clinic should be followed to control these costs. The physicians' share of the dollar is shrinking because of pharmaceuticals and hospitals. **Representative Henbest** added that the pricing of physician services has been discussed, adding that somehow we must get to the pricing of the hospitals and imaging services. As long as $1,500 for an MRI is acceptable reimbursement, people will have it done.

Representative Marriott was interested in the national waste in health care spending of $1.2 trillion, with $312 billion in clinical waste and $210 billion of that was defensive medicine; he asked what we can do to stop that. **Dr. Dammrose** replied that some providers use defensive medicine as an excuse. Doctors should be trained to follow evidence-based practices. BlueCross has employed trainers to conduct evidence-based training. Training doctors to follow evidence has not typically been done in medical schools.

Cochairman Collins thanked **Dr. Dammrose** for his time.

Representative Bilbao moved to accept the minutes of October 23, 2008 as written. Representative Marriott seconded the motion. The motion carried by unanimous voice vote.

Representative Collins thanked **Representative Henbest** and wished her well.

Representative Henbest offered some comments on the Nursing Advisory Council. An effort will be made to bring legislation that will expand the Nursing Group Advisory Council and the work of the Department of Labor to all the health care shortages throughout the state. **Representative Wood** and **Senator McGee** also sit on the Advisory Council and will review the draft legislation with the hope that the final draft would be ready by January; it has a $90,000/year price tag. They received a commitment from the Idaho Hospital Association for one-half that amount.

Being no further business, **Cochairman Collins** adjourned the meeting at 3:25 p.m.