REVISED MINUTES *
Approved by the Task Force

HEALTH CARE TASK FORCE

July 16, 2009
Boise, Idaho

Members present were Senators: Co-chairman Dean Cameron, Joe Stegner, John Goedde, Patti Anne Lodge, Tim Corder, John McGee; and Representatives: Co-chairman Gary Collins, Sharon Block, Fred Wood, John Rusche and Elaine Smith. Absent and excused were Senator Nicole LeFavour, Representative Carlos Bilbao and Representative Jim Marriott. Legislative Services staff present were Paige Alan Parker, Amy Castro and Charmi Arregui.

Others present were: Senator Chuck Coiner; Representative Sue Chew; Representative Judy Boyle; Bill Deal, Director, Department of Insurance; Molly Steckel, Idaho Medical Association and Idaho Psychological Association; Louis Aaron, National Association of Independent Business; Russell Duke, Central District Health District; Steve Thomas, Idaho Association of Health Plans; Woody Richards, Julie Taylor and Stephen Ryter, Blue Cross of Idaho; Joie McGarvin, America's Health Insurance Plans; Tom Lawson and Steve Millard, Idaho Hospital Association; Corey Surber, Saint Alphonsus; Kurt Stembridge, Glaxo Smith Kline; Mike Gwartney, Director, Department of Administration; Teresa Luna, Department of Administration; Sara Stover, Department of Financial Management; Donna Yule, Idaho Public Employees Association; Kathie Garrett, Partners in Crisis of Idaho; Jeremy Pisca and Benjamin Davenport, Risch Pisca, PLLC; Alex LaBeau and Jayson Ronk, Idaho Association of Commerce & Industry; Bill Roden, Delta Dental; McKinsey Miller, Gallatin; Dick Schultz, Paul Leary and Jane Smith, Department of Health & Welfare; Steve Tobiason, HBCI; Suzanne Budge, National Federation of Independent Business and SBS Associates; Amy Holly, Business Psychology Associates; John Watts, Veritas Advisors; Peg Munson, Tracy McMaster and Dede Shelton, American Association of Retired Persons; Martin Bilbao, Connolly Smyser; Colby Cameron, Sullivan & Rebeger; Denise Chuckovich, Jesus Blanco and Teri Barker, Idaho Primary Care Association; Richard Rainey, Regence BlueShield of Idaho; Larry Benton, Benton, Ellis and Associates; and Betsy Russell, The Spokesman Review.

Co-chairman Senator Dean Cameron called the meeting to order at 10:09 a.m. **Senator Cameron** said the focus of this meeting was to update everyone on specific issues since the end of session.

The first presenter was **Mr. Mike Gwartney**, Director, Department of Administration, who reported on the state health insurance program - changes made and changes anticipated in the future. **Mr. Gwartney**'s PowerPoint presentation, entitled "State's Group Insurance Programs,"

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* In 2nd paragraph above (attendees):
(1) "Ann Holly, Bonneville Power Administration" was corrected to:
"Amy Holly, Business Psychology Associates; and
(2) "Larry Benton, Benton, Ellis and Associates" was added to attendees.

is available in the Legislative Services Office and on the Health Care Task Force web page, http://www.legislature.idaho.gov/sessioninfo/2009/Interim/interimcommittees.htm#healthcare. **Mr. Gwartney** stating that surveys were taken and a meeting was held with the CEC Committee over the past two years. The result was the Governor's Total Compensation Project Goal: Develop a total compensation plan for state employees with a cost for salary and benefits that is approximately equal to that of the major private sector employers in the state of Idaho. "Total compensation" is defined as the sum of salary, insurance benefits, and pension plan costs.

Mr. Gwartney emphasized that medical insurance benefits need to be balanced across the total compensation plan. A chart comparison of state total compensation compared to the private sector reflects 15% lower state average salary differential, 12% state higher average medical insurance cost and 200% state higher average pension cost, totaling a 6% lower state average for total compensation compared to the private sector. **Mr. Gwartney** pointed out that the current situation is that the state's cash compensation is less than market, the medical plan is better than market, and the pension plan is much richer than market. **Mr. Gwartney** said that the some of the companies used for comparison were Simplot, Boise Cascade, Idaho Power, Albertson's successors, and Blue Cross of Idaho. He emphasized that Idaho does not compete with other states with regard to salaries, except in limited circumstances. He added that the competitive focus of the state is on those companies from whom we hire and to whom we lose employees, tempered by the realization that the state probably neither can nor should compete with the highest paying private sector companies or government entities.

Mr. Gwartney shared concerns about total compensation issues:
- Average age of employees in medical plan is 47;
- Average age of new hires is 37.1;
- At least one-third of the state's employees will be eligible to retire in the next ten years.

Mr. Gwartney emphasized that state salaries need to be more competitive at some point in time and be balanced with other benefits. He said that currently the state pays 91% of medical premiums, compared to private sector paying 90% of employee premiums and 80% of dependent premiums. Currently the state pays about 75% of total covered medical charges while private sector employers are at or are targeting 70% of covered charges. Total covered charges include not only premiums, but employee paid deductibles, co-insurance and co-payments.

Mr. Gwartney stated that the state's medical/dental insurance plans are funded on a modified, self- insured basis. This offers the state the favorable financial benefit of a self-insured plan, without the ultimate liability of a truly self-insured plan. He said the overall administrative charge on the state's plan is less than 6% of annual premiums ($21.28 per member per month) and the premium tax (part of the administrative charge) is about 1.4% of annual premiums. Thus, approximately 94% of premiums go to cover claims incurred by employees and their covered dependents. With regard to cost sharing, **Mr. Gwartney** said that the current cost share ratio is 75% state and 25% employee. The ultimate goal is to move the cost share to 70%/30% over the next four years. He added that increased costs historically have been managed via changes in one or more of the following:
- Increased state contribution (appropriation);
- Increased employee contribution;
    - Increased premiums;

    - Increased deductibles, etc.
- Plan design changes.

Mr. Gwartney went over medical/dental appropriation components for FY2010, implementation of drug formulary (narrowing list of drugs down for buying power), hourly cost of medical benefits for part-time employees, annual appropriation per employee, and FY2009 reserve requirements at 95% and at 90% confidence levels. **Mr. Gwartney** said that a task force worked on the part-time employee situation, including a survey of major companies, and came up with two options: moving qualification for part-time benefit coverage from 20 hours to 30 hours worked per week; or a bracketed plan where an employee who works 20 hours per week (half-time) pays for 40% of benefits. He emphasized that the state did not want to leave part-time employees without coverage, adding that costs were about the same for the two options. Coverage was not taken away from part-time employees, but they must now pay more for that coverage. **Mr. Gwartney** ended by saying that the deficits in reserves for FY2007 and FY2008 were intentional because excess reserves were used to meet premiums. For FY2009, the reserve was $837,940.

Senator Cameron commented that with regard to health insurance benefits, the Legislature is not involved, outside of appropriations, and asked **Mr. Gwartney** what he saw to be the role of the Legislature in determining and participating in these decisions. **Mr. Gwartney** said it was not an easy question to answer, but replied that the Legislature's role is to confirm that the competitiveness/benchmark being used is appropriate, adding that "their feet should be held to the fire on the finance side, and you've done that very well. You've got to know exactly how we get to the reserve calculations, and your fine staff looks at the actuary reports . . . and no less than annually, the Legislature should get a briefing on what is going on." According to **Mr. Gwartney**, the Legislature, in addition to its review of appropriations, should also review the adequacy of the reserves and participate in task forces.

Senator Cameron discussed how reserves are determined. His understanding is there are two components for calculating reserves: (1) the contractual component, which he assumed is determined by the Dept. of Administration, **Mr. Gwartney**, and the state's current carrier, Blue Cross, and (2) the actuarial component based on an actuarial study conducted by Milliman. **Mr. Gwartney** responded that he is adverse to paying a risk charge to the carrier. The 10% reserve based on total premium dollars is negotiated with Blue Cross, adding that the actuary is involved in that. **Mr. Gwartney** said the department is at the disposal of the actuary, who is asked to calculate reserve requirements at a 95% confidence level ($73,109,115 total reserve required) and a 90% confidence level ($51,202,472 total reserve required).

Senator Stegner asked who was serving on the task force that has been meeting for seven months to discuss adjustments to part-time employee medical benefits. **Mr. Gwartney** answered that people from state agencies that had many part-time employees had been targeted for service as well as human resource people. Currently on the task force are Speaker Lawerence Denney; Senator Charles Coiner; Representative Dennis Lake; Judie Wright, who was with the Division of Human Resources and currently with DFM; Patrick Hodges, Department of Lands; Ray Greene, Fish & Game Department; Mike Kimball, Department of Health and Welfare; Teresa Luna, Rebecca Fry and Cynthia Ness, Department of Admininstration; Jane Buser, Boise State University; Pamm Juker, Department of Agriculture; Brandon Woolf, State Controller's Office;

and Keith Bybee, Legislative Services Office.

Senator Stegner said he understood that adjustments had been made to benefits for part-time employees, asking to whom the term "part-time" applies. **Mr. Gwartney** replied: "We are going through a process defining what part-time is, an example being higher education. We have a professor on a twelve-month contract who elects to get paid over nine months, so that is a full-time contract. So we sat down with BSU and other universities agreeing that is a good definition. On the other side, we have adjunct professors who work six months; they are part-time employees. We have to be very careful about this, to sit down with Labor and Fish & Game because of their federal involvement, so we're going to get a definition on those so we won't have to give money back to the federal government. Some of it is in process and some has been resolved, but in any case, what we want to show is flexibility and we're not going to make exceptions just because someone doesn't like it. If there are reasons for exceptions or redefinition, we're happy to do that." He said that decision is being put off until October, 2009, to allow time to work through these issues.

Senator Stegner said the Legislature has been hearing from state employees regarding the part-time issue and asked: How did we get into this situation; does one size fit all; and is the state health insurance plan used to attract good part-time employees in disruption? **Mr Gwartney** stated that there have not been changes regarding who is a part-time employee in higher education across the board. He recognizes that change results in disruption. Part of the problem is that there are dependents on the state health insurance plan that should be on someone else's plan and that the taxpayers need to be considered.

Senator Stegner said he has no objection to review of classifications, definitions and appropriateness of medical benefits; he believes that the frustration from the Legislature is the confusion about the role they play in participation of this process and ultimately signing off on what is essential to basic state policy in the state of Idaho. He asked what the proper role is of the Legislature. He also asked if **Mr. Gwartney** had thought about classifications of temporary and part-time employees. **Mr. Gwartney** said he has nightmares about this, and the state is the only operation he's ever been around that treats temporary employees as part-time employees. The reason temporary employees are on the books is because agencies don't get full-time funding. But temporary and part-time employees are treated like full-time employees with regard to benefits. He says this needs to be straightened out, affirming that the Legislature will have to be involved in this **Mr. Gwartney** said this process will create definition issues, and as the state takes the benefits down, the goal is to put that money savings back on the salary side for employees for better balance. In the interim, he said there is general fund money.

Representative Rusche inquired about HB173 (2009) with regard to retiree benefits and the establishment of an advisory committee. **Mr. Gwartney** said that the Department of Administration is formulating that advisory committee that will include **Senator Charles Coiner** and **Representative Anne Pasley-Stuart**, as well as a state retiree and a state employee. A broad spectrum of people will be represented. The plan is to run every issue by this advisory committee.

Senator Goedde asked what the waiting period was for new employee medical benefits. **Mr. Gwartney** said that medical benefits become effective the first day of the month following the

hiring date. **Senator Goedde** said that the wait period, in industry, is more like ninety days.

Representative Wood asked about the process gone through when changes are made to benefit plans, in addition to the advisory committee established by HB173. **Mr. Gwartney** said that surveys are taken to remain competitive, the financial side is examined by insurance advisors and actuaries, and the health programs in other states are examined. A plan is then formulated that is presented to the Governor; in the interim, informal conversations with legislators are conducted. **Representative Wood** asked about real health care reform and changes in the delivery system, and what is being thought about in the future. **Mr. Gwartney** said that about $5 million is being taken out of drug company pockets, a large cost savings, maintaining prescription availability for employees; contracts have been negotiated with regard to utilization review for better balance; efficient use of networks has been encouraged. **Mr. Gwartney** said that in the future he will meet with **Health and Welfare Director Richard Armstrong** regarding negotiating with providers to give the state health insurance program more leverage.

Senator Cameron thanked **Mr. Gwartney** for his attendance and information and expressed hope that, at a minimum, **Mr. Gwartney** would come back often to enhance communication so that legislators can better understand the decisions being made by the department in order to better represent their constituents.

Senator Cameron asked **Jane Smith**, Administrator, Division of Public Health, Department of Health & Welfare, to address the task force on the Idaho Immunization Program. He asked: "How did we get into this situation and how can we get out?"

Ms. Smith's PowerPoint presentation is available in the Legislative Services Office and at http://www.legislature.idaho.gov/sessioninfo/2009/Interim/interimcommittees.htm#healthcare. She explained the FY2009 funding sources for vaccine as being: $19,859,926 from the Vaccine for Children Program (VFC), an entitlement grant from the Centers for Disease Control (CDC); $1,754,111 from the 317 program, discretionary grant funds from CDC; and $2,877,069 from the state general fund, providing a seamless revenue stream for providers for vaccine. **Ms. Smith** said that the immunization program supplied all but a few of the recommended pediatric vaccines to VFC-enrolled providers to vaccinate all children (0-18) regardless of income, insurance status or type of health care provider. Federal and state funds are pooled to cover the cost of vaccines (not administration). However, the withdrawal of the state general fund support for the Immunization Program by the 2009 Legislature shifted Idaho from universal-select to VFC only. This has impacted physicians and clinics in the following ways:

- Insurance providers must purchase vaccine for insured children;
- Privately-purchased and federally-supplied vaccine must be monitored separately; and
- Children must be screened for VFC funding eligibility.

To operate as a VFC only program, The department has updated the Immunization Program plan by:

- Incorporating best practices and lessons learned from other states;
- Working with medical providers to define new roles regarding vaccine purchase and administration;
- Increasing parent education;
- Continuing to support activities of the physician-initiated, state-wide immunization

coalition; and
- Working with insurance groups to minimize the impact to parents.

Ms. Smith said that as a VFC only state, vaccines purchased with federal moneys must be used for VFC eligible children. Now, these children cannot receive any of the vaccine purchased with federal dollars but must be given vaccine purchased by the physician, clinic, hospital, or health district, further screening would be necessary for billing, and many parents do not understand vaccine coverage, so education is necessary. Providers must order separately for ineligible children and cannot secure the favorable federal vaccine rates. An effort was made to create a purchasing pool using moneys from private sources, but only one response was received on the department's Request for Proposals, and that was for vaccines at retail cost.

Senator Stegner asked about the actual inventory of these vaccines prior to the change, asking if the state had one central purchasing station or warehouse and shipped out vaccines to users around the state. **Ms. Smith** said it was easier than that; vaccine and antigens were purchased off a federal contract and would go to a distributor who would ship to providers, since everyone was universally covered. Now there is no universal coverage. For private pay (insured clients), the health care providers have to order the vaccines themselves. They cannot order off a federal contract or through Health & Welfare.

Senator Corder asked what the difference in cost would be to health care providers who cannot buy off a federal contract. **Ms. Smith** said it was hard to say, since antigens are so different in cost, but to immunize a child from birth to age 18, a full series would cost about $4,300. Antigen costs and how much is purchased would determine the cost for a health care provider in anticipation of patient needs. She said that multi-use vials are cheaper than single dose, but the health care provider would need to anticipate the demand so that a ten-dose vial could be used before the vaccine outdates.

Representative Wood asked if that $4,300 price tag was the federal contract price tag or private price tag. **Ms. Smith** said that $4,300 was the private cost and she did not know the federal cost, offering to get that information for the task force.

Representative Rusche, a retired pediatrician, said that most pediatricians have one vial of vaccine bought at the federal government purchase rate, which is at a discount of anywhere from 50% to 65% of the private market. He said by pooling state and federal moneys together, citizens were offered a 30% to 50% discount on vaccine costs. The fact that the state is no longer able to do that is significant.

Senator Cameron asked if it was a federal government decision that their federal purchasing power could no longer be used or a state decision based on financial difficulties. **Ms. Smith** said the federal government will not allow purchases off a federal contract unless state funds are part of the funding. Physicians cannot purchase off the federal contract with private dollars.

Senator Cameron asked if that was the same with private insurance companies. **Ms. Smith** answered that is true unless the insurance company money is collected by the state and placed in a dedicated account. By channeling the private money through the state, the federal contract rate can be accessed.

Senator Cameron recalled that when **Ms. Smith** came before JFAC during the past session, he got the impression that **Ms. Smith** thought that stimulus dollars might be available to prolong this problem from occurring for a year or until a transition could be made. **Ms. Smith** said the department thought there were going to be stimulus moneys in the amount of $2.9 million but that amount was cut to around $840,000. In addition to not receiving the anticipated stimulus dollars, the department also experienced a cut in the CDC award because of Idaho's low immunization rates. Idaho's population estimates for children under age 18, which were more accurate than the CDC's, got discounted. **Ms. Smith** said that change became effective on July 1, 2009, and was not the result of a rule change.

Ms. Smith discussed the vaccine purchasing pool. Only one response was received from a pharmaceutical manufacturer and one "no bid" from a distributor. The one manufacturer's bid did not include all antigens and offered no economic advantage for the purchase of vaccines (prices were private sector costs or greater). Due to this lack of response, the department was not able to move forward with the purchasing pool.

Ms. Smith said that public health concerns are:

- The financial burden of purchasing vaccines has caused some health care providers to postpone or stop vaccinating insured children;
- Parents of insured children are confused and upset because they are not sure how to access immunizations;
- Every time a child is referred, it reduces the likelihood that they will be vaccinated;
- Increased referral to the local health departments places a heavy client load and financial costs on them;
- Will this lead to even lower immunization rates?

Ms. Smith pointed out that Idaho did not do well as a universal state. It has a lowest measles vaccination rate than does Indonesia, Pakistan and Croatia. Idaho has lower polio vaccination rates than Botswana, Latvia and Sri Lanka. Idaho is at a 57% immunization rate, the lowest in the entire country, and could go even lower. **Ms. Smith** explained there are four factors that can help predict whether or not a child will complete their immunizations on time:

1. 1st dose of DtaP is received on time;
2. 3rd dose of DtaP is received on time;
3. Being a younger mother;
4. Having more than one provider.

Ms. Smith said that vaccination rates are low among children entering kindergarten; 85% of children entering kindergarten were vaccinated according to state requirements; 9.5% of children entering were missing something. The vaccines to target are the 5th DtaP and 2nd MMR.

Senator Goedde asked about the 57% immunization rate and the 85% rate for children entering kindergarten. **Ms. Smith** explained that the higher rate is due to having to be immunized in order to be enrolled into kindergarten, unless a waiver is signed. **Senator Goedde** asked about children under school age and how are parents notified about needed immunizations. **Ms. Smith** said this is between the physician and the family to keep a child on schedule. Parents are educated as to that schedule, usually given in hospitals at birth, and should be on a regular schedule after that. She said an immunization registry had been looked into as well as reminder

notifications as a pilot project to hopefully increase immunization rates.

Representative Rusche asked if Idaho had an entity to look at best practices throughout the country and to determine what Idaho might do to perform better. **Ms. Smith** said that an immunization coalition has been formed recently to look at commonalities of successful states, such as Minnesota, which ranks 6th, and to look at what the states who do **not** succeed have in common. **Representative Rusche** said he would love to see this coalition come up with a plan and perhaps recommendations as to how the department, the Legislature and other entities can support such recommendations before the next session.

Senator Cameron said that the decision was made by the Governor and the Legislature to only provide immunizations for those without insurance with the anticipation that a vaccine purchasing pool would be formed. **Ms. Smith** said that a vaccine purchasing pool group, composed of insurers, physicians and others in order to take advantage of their collective economic power as a collective purchasing group, was formed, but the bid that came back was not competitive. She said that Washington is a universal state and had invited Idaho to be in a purchasing pool with Oregon and New Mexico.

Senator Cameron asked where Idaho was headed. **Ms. Smith** said that the department is looking at how Idaho can make the transition easier through the education of families and health care providers. **Mr. Dick Schultz** of the department said that there has been some discussion about using part of the premium tax which might be added to the general fund to fund the immunization program. He said that the department could facilitate that discussion.

Senator Cameron asked who was participating in the purchasing pool. **Ms. Smith** answered that it was Blue Cross along with two others, St. Lukes Hospital and Altius Health Plans, that might have joined. **Senator Cameron** said it was his understanding that up to the last day there were no bids, and on the last day one bid was received. **Ms. Smith** affirmed that to be correct. **Senator Cameron** expressed frustration about the appearance that parents responsible enough to buy insurance may think they are being penalized.

Senator Corder asked how we could help local health care providers, adding that he is getting calls from constituents reporting that they have been told by physicians that immunizations will be $600 - $800 each and to come with that money. He said that since July 1, 2009, parents are choosing not to immunize simply due to prohibitive costs and no questions are being asked of these parents as to whether their insurance will provide coverage for immunizations. **Ms. Smith** agreed that there has been a knee-jerk reaction by some health care providers who are upset that they must purchase vaccines up front and disappointed that the vaccine purchasing pool did not come to fruition. She hopes that some of this will transition.

In response to **Senator Cameron, Sara Stover**, Health and Human Services Budget Analyst, Department of Financial Management (DFM), said that it was not the Department of Health and Welfare's request to eliminate state funding for the immunization program, but was a recommendation from the Governor. **Senator Cameron** asked how the Governor made that determination. **Ms. Stover** responded that it literally came down to the last days of the preparation of the Governor's budget recommendations. The budget had to be balanced. She

said this big policy issue was not necessarily one they wanted to leap into, but it came down to fiscal responsibility.

Mr. Russell Duke, Director, Central District Health Department, presented an immunization update from the health district prospective to the task force. **Mr. Duke** stated that he concurred with **Ms. Smith** especially with regard to Idaho's low immunization rates and the challenges Idaho faces. He referred to a Resolution to Support Universal Vaccine Supply in Idaho adopted by the Idaho Association of District Boards of Health in June, 2006. Effective July 1, 2009, he said that the health districts in Idaho are in the same situation as private health care providers in terms of having to purchase vaccine, the only difference being that the health districts have the advantage of purchasing vaccine under a Minnesota multi-purchasing agreement. He said the cost to the health districts is considerably lower than the $4,300 for a full series vaccination. However, the lower cost is only available to government health care facilities. He said there are many questions about cooperative purchasing and the relationship with private insurance companies. A certain inventory of vaccine must be maintained. The seven Idaho public health districts are purchasing vaccine on a month-to-month basis and are concerned about the impact if 33% of private health care providers get out of the business of vaccinating children. He said that the public health districts must utilize funds from reserve accounts to purchase vaccine since this was not included in their budget for FY2010, which will place additional strain on their already diminishing resources. He said that all seven public health districts have or will be creating or modifying existing billing systems so that private insurance can be billed for the vaccines. According to Idaho Code, public health districts can charge no more than actual cost. **Mr. Duke** said that, given past experience in billing insurance companies, not all claims will be 100% reimbursed and tax dollars will make up the difference. He said that a minimum of five visits are required for children to receive immunizations required for school and that the public health district cost for each visit averages between $300 and $500.

Mr. Duke said the public health districts are in the process of notifying all private providers of their plans to continue immunizing all children regardless of insurance status. Six of seven public health districts have privately purchased vaccine and have served insured children since July 1, 2009. The other district will begin serving insured children on August 3, 2009. Each public health district has updated its website to reflect the changes occurring as a result of the state of Idaho's decision to discontinue universal status, what this means to families, and what families need to do to prepare in advance of their immunization appointments. Similar information will also be available at each clinic site.

Representative Rusche inquired about the 150 new infants monthly coming to clinics; he wondered about other pediatric care offered. **Mr. Duke** said that the public health districts offer no other services, except immunizations.

Representative Block expressed concern about access to immunizations in rural areas. **Mr. Duke** said that public health districts offer services in 44 counties; he said the challenge would be in, say, Boise County where immunizations are offered every two months, but local health care providers may be able to immunize, although they cannot charge for their services if they administer government purchased vaccine.

Senator Corder asked if public health districts could contract with physicians in the larger towns. Mr. Duke stated that the public health districts had not looked into contracting with physicians.

Senator Goedde asked if parents were notified when immunizations are due. **Mr. Duke** said the public health districts do when they have knowledge of the child's immunization record. The public health district will then recommend that the child be taken to the child's health care provider or to the public health district.

Dr. Stephen Ryter, Medical Director, Blue Cross of Idaho, is a board certified pediatrician. He reminded the task force that Idaho is 50th out of 50 states with regard to immunization rates. He said that in Idaho resistance to immunization is common and resembles the surrounding states in this regard. He mentioned that pediatricians have as their focus health of children and immunizing and are thus more prone to send immunization reminders to their patients, while family physicians have a broader spectrum of practice and are often consumed with older patients with chronic conditions and thus may be less likely to send reminders. **Dr. Ryter** said that vaccine schedules are complex, particularly if patients get off schedule. He said that Blue Cross of Idaho insurance contracts typically have first dollar coverage for immunizations, so parents do not have to pay up front. There are exceptions. He said that the group purchasing cooperative was a good idea and Blue Cross is firmly committed to it. Blue Cross was shocked and disappointed when the bids came in. **Dr. Ryter** believes there must be a fix to this situation so that a single supplier can minimize office disruption, improve immunizations rates and have a net lower cost. His estimate for vaccines annually was $4.5 million and that translates to higher premiums for the insured. He provided the task force with Centers for Disease Control vaccine price lists, which are available in the Legislative Services Office. **Dr. Ryter** reiterated that the Minnesota Purchasing Cooperative is probably about 27% higher than VFC and the commercial market is somewhere around 40% to 50% higher.

Dr. Richard Rainey, Idaho Medical Director, Regence BlueShield of Idaho, stated that he also was a pediatrician. He said that Regence supports and promotes childhood immunizations, covers when benefits are available, that the vast majority of the Regence insurance contracts do have immunization benefits, covering the nationally recognized vaccines. **Dr. Rainey** said Regence has an abundance of health information on its website that can be used to understand immunizations. He said Regence has in place a system for reimbursing providers for administering vaccines, and this system accommodated the July 1st changes. He said vaccines are administered in two components, an ingredient cost (at average wholesale price plus 10%) and reimbursement for administering the vaccine, generally between $31 and $34 for injecting the first vaccine and between $16 and $18 for injecting a second vaccine during the same office visit. He termed this reimburse as "reasonably generous." **Dr. Rainey** said that with regard to the July 1st changes, mailers about the Regence reimbursement policies were sent out to all primary care physicians Regence contracts with and posted that information on the Regence website. He said that Regence would like to participate in coming up with solutions to the immunization situation. He said that with regard to newer products, there is up-front coverage in the majority of cases, with variations for deductibles and co-insurance. He pointed out there are a few members under old contracts without coverage. With regard to coverage in the self-funded groups, this is customized and varies a bit, some covering with deductible, maximum or co-pay for vaccines.

Dr. Rainey commented on the up-front money scenario, stating that providers have not had experience with this situation. He clarified that if a child is uninsured, the child is still covered by VFC . The vast majority of members do have coverage and would not have to pay up-front costs. He clarified that in the high deductible products, many insureds, but not all, have first dollar coverage. **Dr. Rainey** suggested for consideration that public health districts quarterly or regularly provide immunizations at private practices. **Senator Cameron** asked **Dr. Rainey** to provide a copy to the task force of the Regence plans that cover immunizations. A copy of the information provided by **Dr. Rainey** in response to this request is available in the Legislative Services Office.

In a follow-up discussion on the Idaho Immunization Program, **Senator Cameron** asked **Ms. Smith** about the dollar amount of $2.8 million the Legislature failed to fund and whether the amount appropriated by the state for this program had remained static over the past. **Ms. Smith** confirmed that the FY2009 appropriation was $2,856,100; however, inflation and the cost of new antigens would add an additional $21,000. The FY2008 appropriation was about $2.6 million.

Senator Cameron said he did not want to put the task force in an awkward position but that decisions were made during the legislative session in expectation of stimulus dollars and/or the purchasing pool might provide cost effective vaccines, but neither occurred as anticipated. Therefore, **Senator Cameron** asked the Department of Health and Welfare how much money it would take to keep the immunization program whole through January when the Legislature convenes. **Mr. Schultz** agreed to come back with this figure after the lunch break.

Senator Cameron reiterated that since this problem cannot be addressed until January, 2010, there are children going without immunizations. He said that **Mr. Schultz** had suggested using premium tax dollars, but **Senator Cameron** said that some of those dollars dip into the general fund and are used for such things as the high risk insurance pool. **Senator Cameron** suggested that there may be other alternatives. The Department of Health and Welfare already receives premium tax dollars for the access card, of which some of those dollars are not currently being used. **Senator Cameron** said that using premium tax dollars for the immunization program might require a statutory change, but that option would permit the purchase of vaccines at the federal rate.

Senator Cameron asked the task force members to think about whether there is a way to make a request of the Governor to use his approximately $7 million emergency fund authority to cover these immunizations until January, 2010. **Ms. Stover**, DFM, said that this might be a feasible idea for the Governor to consider. **Senator Cameron** said this discussion would continue after lunch when the needed amount could be determined by Health and Welfare.

Mr. Paul Leary, Division of Medicaid, Department of Health, Department of Health and Welfare, addressed the task force following the lunch break on the status of federal approval of changes to the state Medicaid plan. **Mr. Leary** handed out a policy status report which is available in the Legislative Services Office. **Mr. Leary** noted that the department was seeking to eliminate out-of-state hospitals from the Disproportionate Share Hospital (DSH) payment program. This report covered cost containment strategy for hospitals, long-term care, pharmacy, mental health, medical, Medicaid managed care contracts, development disabilities, non-emergency medical transportation and cost sharing for Katie Beckett families, showing the

effective date of the change, the statute and rule affecting the change and the status of the state Medicaid plan approval of the change.

Representative Rusche noted that average drug pricing for pharmacies may depend on volume, with the smaller pharmacies having high drug costs. **Mr. Leary** answered that the department is sensitive to independent pharmacies, as opposed to the large chain pharmacies, dealing with different volumes, in drug pricing.

Senator Cameron said he had understood there was a proposed change that the federal government had declined to approve. **Mr. Leary** said that the federal government declined to accept the removal of non-emergency medical transportation from the Medicaid basic plan. **Senator Cameron** asked if he was expecting approval on other proposals and **Mr. Leary** said he felt fairly confident on approval of these changes. **Senator Cameron** asked **Mr. Leary** to keep the task force informed of future reforms and asked him to add a column to his report showing anticipated savings on each category.

Senator Corder said that while he supports the use of companion care, as opposed to more expensive care, he asked what plans have been undertaken to oversee possible waste in the companion care program, although it possibly saves money. **Mr. Leary** said that oversight is part of that program, which is being used successfully in assisted living facilities.

Representative Block commented that it was good news that **Mr. Leary** is confident of approval of pending Medicaid plan changes but wondered how the one disapproval would affect the budget. **Mr. Leary** answered that the non-emergency medical transportation item had a budget impact of $950,000, but with the availability of stimulus moneys, the actual impact will be only about $200,000.

Senator Cameron redirected the task force's attention back to the immunization issue and opined that, based on information made available by the Department of Health and Welfare, approximately $2.1 million would be needed to keep the immunization program going through the end of 2009. He noted that the Governor's $7 million emergency authority is tied to personnel costs. **Senator Cameron** said the options available are: do nothing; ask the insurance companies how many individuals do not receive first dollar coverage under their insurance contracts and refer the uninsured and non-covered individuals to the public health districts; or ask the Governor to utilize his authority to transfer up to a 10% of funds between agencies to cover the $2.1 million shortfall until the Legislature convenes in 2010. In the interim the task force would need to consider alternative funding for the $4.2 million state funding share.

Ms. Amy Johnson, LSO Senior Budget & Policy Analyst, cautioned that the 2010 Legislature would have to cover the $2.1 million of transferred funds.

Representative Wood asked whether federally qualified health centers are considered a private provider or if they are eligible to purchase vaccine at the federal rate. **Mr. Schultz** said he believed that federally qualified health centers can purchase directly from manufacturers at cost. **Representative Wood** asked if they would still be under the same guidelines to keep track of those eligible for the VFC program and be required to segregate vaccines for the eligible and ineligible children. **Mr. Schultz** answered that they would be required to track the VFC eligible

from the purchased vaccine and are responsible to the department for the federal VFC program vaccine provided, which would be kept separate from the vaccine that they purchase directly from the manufacturer. **Representative Wood** inquired if they would purchase all vaccines at the same price or would they purchase a subset of the vaccine at the retail price. **Mr. Schultz** said it would be in their best interest to purchase a subset of the vaccine at the retail price and still get free vaccine from the federal government through the state of Idaho.

Senator McGee asked **Mr. Schultz**, as an administrator, for his opinion on a possible recommendation to the Governor to transfer funds, what the outcome of such transfer might be, and if the department was comfortable with such a recommendation. **Mr. Schultz** responded that the department would be comfortable doing anything the Governor would support, believing a transfer of funds would buy some time to figure out a long-term resolution. He cautioned that if the transferred funds were not returned to the department, it would put pressure on the general fund.

Senator McGee asked if the task force could only make a recommendation. **Senator Cameron** responded that he agreed; he said if the task force were to request that the Governor and the department make that $2.1 million shift, it could come in the form of a motion and it would be up to the Governor and the department whether to accept that. Then, the Legislature would be responsible to come up with that money. If the task force wants to continue the immunization program and to improve it, then a funding solution must be found. He added that the department's budget, especially for Medicaid for FY2010 and FY2011, is not pretty and that requirements from the federal government further complicate the situation. **Senator Cameron** believes that the lack of immunizations will actually end up costing the state more and buying vaccine at the higher retail price when it could be bought at a discounted, federal price is foolish.

Senator Goedde wondered if the public health districts would be incurring additional expenses which could cause them to ask for a supplemental appropriation. **Senator Cameron** said this could be anticipated, given that the department would be essentially using reserve funds to fill this immunization gap, funds normally used for building construction and maintenance. **Senator Goedde** added that the fiscal impact to the state might be something less than the $2.1 million.

Senator McGee moved that this Health Care Task Force authorize the co-chairs to send a letter to the the Governor and the Department of Health and Welfare recommending that the Governor use his ability to shift funds between Division to the immunization program, through the end of 2009 in an amount not to exceed $2.1 million. The motion was seconded by Senator Stegner and the motion passed unanimously by voice vote.

Senator McGee stated that this could ultimately result in a cost savings to the state and make a difference in the state rankings for immunizations, since recent inaction has hindered progress.

Representative Rusche asked how long it would take for practices, hospitals, clinics and health districts to then get back on track, if requested additional immunization program funding was made available. **Ms. Smith** answered that it would not take much time. **Ms. Johnson** noted that some providers have purchased vaccine at the higher, market price.

Mr. John Watts, Idaho Primary Care Association (IPCA), introduced **Ms. Denise Chuckovich**, Executive Director, Idaho Primary Care Association, and notified the task force of some good news. **Mr. Watts** stated that IPCA is a network of 13 federally qualified health centers throughout the state. The IPCA has recently be informed that it has been selected for a grant from the Qualis Grant Foundation. This is private money, with no match or public funds required, which will allow the IPCA to put together a team to determine the medical gaps in the state and to do pilot testing on providing services for primary and preventive care in an ongoing and meaningful manner.

Ms. Chuckovich spoke on the Patient Centered Medical Home model. She said that everyone is painfully aware of the debates going on in Washington, D.C. about what our health care system should look like, what is broken, escalating costs, and people without access. She said that one piece of the new discussion evolving is the idea of the Patient Centered Medical Home, which she believes can make such a difference in preventive care, health care costs, improved health, better access and outcomes.

Ms. Chuckovich said that in 2007 the Governor put together the Select Committee on Health Care that identified the Patient Centered Medical Home as one of their key recommendations made to the Governor. She said the developing Idaho Health Data Exchange was helping integrate health care systems and connect people's health care records between primary care providers, hospitals, x-ray and labs for improved data exchange. She said that some people using the catastrophic fund could be identified and incorporated into the Patient Centered Medical Home, hoping to get them stabilized and off the fund. She said there is stimulus money coming to Idaho to support the Electronic Health Record, another piece of this model which could prove to be critical. **Ms. Chuckovich** said there was a medical home summit in June in Boise, sponsored by the Governor's Select Committee, that featured national speakers and created lots of interest.

Ms. Chuckovich shared the key features of the Patient Centered Medical Home and gave the members a handout which is available in the Legislative Services Office. Core elements of a Patient Centered Medical Home include:

- **A personal physician**
  - Patients assigned to personal provider who is first contact for continuous, comprehensive care;
  - Responsible for all patient's care needs.
- **Team Care**
  - Health care team collectively take responsibility for ongoing care.
- **Whole person orientation**
  - Take responsibility for all patient needs by delivering or arranging care.
- **Coordinated and integrated care**
  - Across all elements of the health care system;
  - Includes specialty referrals, hospitalizations, linkages;
  - Tracking of patients, referrals and tests.
- **Quality and safety**
  - Addressed by implementation of continuous quality improvement and voluntary recognition process of medical errors.
- **Enhanced Access**

    - Via open scheduling, expanded hours and new options for communications.
- **Payment Reform**
    - Recognizes the value of the Patient Centered Medical Home, pays for coordination and electronic communications with patients, supports information technology use such as electronic health records and the health data exchange.

Ms. Chuckovich shared that IPCA has been selected from 41 applicants from 32 states to serve as one of five Regional Coordinating Centers (RCC) across the nation for the Safety Net Medical Home Initiative by the Commonwealth Fund and Qualis Health. IPCA will receive $125,000 per year over the course of the four-year initiative to work with 13 Idaho safety-net primary care clinics and to facilitate their transformation into Patient Centered Medical Homes. The four-year initiative builds on the work of the Governor's Select Committee and will include work with the safety-net primary care clinics to help them reach high benchmark levels of quality, efficiency and patient experience. **Ms. Chuckovich** added that a Stakeholders Advisory Group, representing the Governor's Office, Idaho legislators, payers, and health policy leaders will work to transform reimbursement policy for medical home services. The Safety Net Medical Home Initiative is sponsored by The Commonwealth Fund which is joined in support of the project by eight co-funders, including Blue Cross of Idaho Foundation for Health. She concluded by saying that there will be a very expensive evaluation of this project done by the University of Chicago, which will be tracking all five RCCs.

Representative Wood congratulated IPCA and thought this would be a perfect setup to help determine the current immunization rate and to affect immunization outcomes here in Idaho. **Ms. Chuckovich** affirmed that this actually was one of the grant's quality measures. She believes this will help to put Idaho in the forefront for initiatives as well.

Senator Cameron stated that this is a challenging time for everyone looking to Congress for health care reform, so he wants to keep the task force informed as to what is going on. He invited **Mrs. Amy Johnson** to inform the task force about national reform.

Mrs. Johnson handed out a packet of information entitled "Health Care Reform Update" which is available in the Legislative Services Office. She updated the members on health care reforms being worked on by Congress, pointing out changes taking place that could affect Idaho. She noted that the President has not presented his own health care reform bill and that separate bills are being developed by committees in the House and the Senate. The President has requested that any health care reform bill that passes Congress not exceed his $1 trillion fiscal note.

Co-chair Senator Cameron then made appointments for the Mental Health Subcommittee for 2009-2010 as follows:

Senator Joe Stegner Co-chair
Senator Patti Anne Lodge
Senator Tim Corder
Co-chair Representative Collins made appointments for the Mental Health Subcommittee for 2009-2010 as follows:

Representative Sharon Block Co-chair

Representative Fred Wood
Representative John Rusche

Representative Collins moved that the minutes from January 27, 2009, be approved with one correction on page 9, paragraph 3, that being to change "Representative Paul Wood" to "Representative Fred Wood." With that correction, those minutes were approved unanimously by voice vote.

Senator Cameron invited members to provide input for future agendas and meeting dates. The meeting was adjourned at 3:10 p.m.