MINUTES

HEALTH CARE TASK FORCE

Boise, Idaho
September 28, 2009

(Subject to approval by the Task Force)

Health Care Task Force members present were Senators Dean Cameron, Joe Stegner, John Goedde, Patti Anne Lodge, Tim Corder, Nicole LeFavour and John McGee and Representatives Gary Collins, Sharon Block, Carlos Bilbao, Jim Marriott, Fred Wood, Elaine Smith and John Rusche. Legislative Services Office staff were Amy Johnson and Paige Alan Parker.

Also present were: Richard Rainey, M.D., Idaho Medical Director, Regence BlueShield of Idaho; Doug Dammrose, M.D., Senior Vice President, Chief Medical Officer, and Woody Richards, Blue Cross of Idaho; Susie Pouliot, Idaho Medical Association; Po Huang, M.D., FACEP, President, Idaho Emergency Physicians, and Tiffany Whitmore, MPA, Telemedicine Coordinator, Saint Alphonsus; Jeremy Pisca and Benamin Davenport, Risch Pisca, PLLC, representing Pharmaceutical Research & Manufacturers Association and Saint Alphonsus Regional Medical Center; Kurt Stembridge, representing GlaxoSmithKline; Ted Epperly, M.D., Program Director and CEO Family Medicine Residency of Idaho; Sara Stover, Department of Financial Management; Cheryl Dunham, Moffatt Thomas Barrett Rock & Fields Chartered, Idaho Association of Health Underwriters; Kathie Garrett, Partners in Crisis; Martin Bilbao, Connolly & Smyser, Chartered; Senator Joyce Broadsword, Legislative District No. 2; Christian Shull, M.D.; Russ Meyers, Eli Lilly & Company; Ken McClure, Given Pursley, LLP; Steve Millard, Executive Director, Idaho Hospital Association; Tony Poinelli, Idaho Association of Counties; Joie McGarvin, American's Health Insurance Plans; Jane Wittmeyer, Wittmeyer & Associates, LLC; Kris Ellis, Benton Ellis & Associates; Steve Hansen, Genentech; Colby Cameron, Sullivan & Reberger; Richard Armstrong, Director, Dick Schultz, Deputy Director of Health Services, Leslie Clement, Administrator, Division of Medicaid, and Paul Leary, Deputy Administrator, Division of Medicaid, Department of Health and Welfare; Amy Holly, Business Psychology Associates; Heidi Low, American Cancer Society and Cancer Action Network; Mike Gwartney, Director, Department of Administration; Bill Deal, Director, Department of Insurance; Dede Shelton, Advocacy Director, AARP Idaho; Suzanne Budge, National Federation of Independent Businesses; Scott Leavitt and Tom Shores, National Association of Health Underwriters; Alex LaBeau, President, Idaho Association of Commerce & Industry; P. Lewis O'Conner, IPC2; Steven Ricks, Idaho Chamber of Commerce Alliance; Joy Wilson, National Conference of State Legislatures (by conference call); Brad Hugun, Portneuf Medical Center; Dick Compton, Idaho Health Data Exchange; and Denise Chuckovich, Executive Director, Idaho Primary Care Association.

Chairman Dean Cameron called the meeting to order at 10:12 a.m.

Senator Patti Anne Lodge moved the minutes of the August 26, 2009, task force meeting be approved with corrections on page one, changing "Senator Gary Collins" to "Representative Gary Collins," and on page 2, changing "$105,000" to "$205,000." The motion was seconded by Representative Carlos Bilbao and approved unanimously by the task force.

Chairman Cameron called on **Senator Joe Stegner** to report on the August 27, 2009, meeting of the Mental Health Subcommittee. **Senator Stegner** informed the task force that not a lot has changed recently regarding the mental health transformation efforts. He recalled that the task force has authorized an independent review of Idaho's mental health system. The Western Interstate Commission for Higher Education (WICHE) completed its review last year, presenting a transformation plan. The Governor was asked to review this plan and agreed to take over plans for implementation. The Behavioral Health Transformational Workgroup was formed by the Governor. However, the wheels came off that effort when the Governor refused to sign the proposed contract with WICHE because it had not gone through the competitive bidding process**. Senator Stegner** reported that the Governor's workgroup is meeting on September 29th to address the competitive bidding issue. He expressed confidence that the workgroup will proceed on this transformation effort, but it will take time. **Representative Sharon Block** added that the subcommittee also received presentations on the results of the Parenting with Love and Limits program within the Division of Behavioral Health, Department of Health and Welfare, and on an overview of policy changes in the Medicaid Mental Health and Substance Abuse Benefits programs.

Representative Gary Collins was asked to report on the Immunization Subcommittee's meeting that occurred earlier that morning. **Representative Collins** reported that this morning's meeting was the subcommittee's first and that there had been good representation of the stakeholders and agencies. Although there was good input, more questions were raised than answered. The subcommittee will meet again on November 4th at which time it should be able to set goals and move forward.

Chairman Cameron reminded that the next task force meeting is on November 4th. The task force members were requested to mark their unavailable dates for a meeting in early December and provide those calendars to the Legislative Services Office. The co-chairs will cooperate on the agenda for the November and December meetings. If a task force member wants to have an item placed on the agenda, please notify the co-chairs. **Chairman Cameron** stated that if any member has health care legislation to bring forward, the legislation needs to be put on the agenda.

Tiffany Whitmore, the St. Alphonsus telemedicine coordinator, and **Po Huang, M.D**., the medical director for the St. Alphonsus Emergency Specialist Program, presented to the task force on "Utilizing TeleHealth to Improve Access to Medical Care in Idaho." A copy of the PowerPoint presentation is available in the Legislative Services Office and on the internet at: www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare.htm.

According to **Ms. Whitmore**, the telehealth program at the St. Alphonsus Center for Advanced Healing was started with a grant two years ago and allows medical expertise to be accessed anytime, anywhere. The program currently has 11 Remote Presence robots: two are at St. Alphonsus in Boise; six are in Idaho hospitals: Cottonwood, Orofino, Grangeville, Cascade, West Valley and Emmett; and three are in Oregon: Baker City, LeGrande and Ontario. Current programs include interactive surgery,

neonatal intensive care, maternal-fetal medicine, the ambassador program, where physicians, family and friends can be remotely present with patients at St. Als, cardiology, intensive care, psychiatric clinics, outreach education and emergency specialist programs. The robots have been used over 1380 times. The telepsychiatry program has served 46 adults and 18 children. The psychiatrist provided through the program is a consultant with primary care being provided by the local provider. Quantifiable benefits of the telehealth program include the prevention of 15 air transports, saving $354,999, serving 184 patients, and providing education seminars to 237 people.

Dr. Huang explained the St. Als Emergency Specialist Program as helping to increase the capability at critical access hospitals on four time-critical diagnoses: massive heart attacks, acute strokes, severe infections and trauma. If a patient can be treated at the local hospital, that should be done. Access is triggered by one phone call, 24 hours daily, seven days weekly, 365 days yearly. The most critical aspect is education. Grand rounds are now available through the internet for physicians and nurses on a monthly basis.

In response to **Representative Jim Marriott**, **Dr. Huang** stated that a live dispatcher is available by phone with a certified nurse readily available. **Representative John Rusche** asked whether the technological infrastructure is sufficient to support these services in the rural hospitals. **Ms. Whitmore** that the program undertakes a full wireless assessment of hospitals where services are being provided. Cottonwood and Orofino had to upgrade their fiber communications capabilities to meet program requirements.

Representative Collins asked who paid the initial cost. **Ms. Whitmore** said the a grant from the Telemedicine Technology Advanced Research Center was used to acquire the first four robots, St. Als added five more robots and two more have subsequently been acquired with a Research Center grant. The robots cost $3,500/month to rent. **Representative Collins** asked how hospitals are billed. **Ms. Whitmore** said that the contract issues are being addressed. Initially, the robots were provided at no cost. As grant funding expires, hospitals will be charged according to proportion of use and for subscribed services. Telepsychology services will be charged on a block time basis.

Senator Cameron asked how insurance companies will be billed for physician consultations. **Dr. Huang** answered that insurance companies have not been charged while the program has been working through the grant. **Senator Cameron** asked if there is a requirement that the physician actually be in the room before there can be insurance company reimbursement. **Dr. Huang** believes that the physician must in there for the initial visit, but isn't sure on this issue. **Senator Cameron** asked if the physician consultant charges less for services provided via telemedicine than in person. **Ms. Whitmore** replied that Oregon requires payment at the same rate.

Senator Cameron asked if there were liability issues. **Dr. Huang** stated that there is greater liability for consultations through telemedicine than over the phone. The malpractice insurance carrier has agreed to cover these consultations if the telemedicine consultation does not exceed ten percent of the physician's practice. The Oregon Board of Medicine has stated that an Oregon license is not required for an Idaho physician providing consultation through telemedicine as long as the patient remains under the care of an Oregon physician at the point of contact.

Senator Stegner asked if the robots were being used in the telepsychiatry program. **Ms. Whitmore** answered that in addition to the robots, stationary telecom's are used in Eastern and some

parts of Northern Idaho to support psychiatrists. **Senator Stegner** asked why the communities served through telepsychiatry are different from those on the telemedicine list. **Ms. Whitmore** replied that the robots are being used for telepsychiatry in Cottonwood, Orofino, Emmett and Cascade. The telepsychiatry program is being expanded to the other hospitals with robots. **Senator Stegner** asked if there are any political problems with that expansion. **Ms. Whitmore** responded that everyone is supportive, but there is a capacity issue. Only three psychiatrists are currently participating in the program.

Senator Nicole LeFavour asked whether the need in the telepsychiatry program was for counseling or for management of medicines. **Ms. Whitmore** answered that med management is the service provided. Also, an inpatient service is available for patients that are hospitalized for a medical problem but who also have psychiatric needs. Initial visits are an hour and follow-up visits are a half-hour. Some therapy is provided during those visits.

Senator John Goedde asked whether St. Als is collaborating with the Idaho Education Network on broadband issues. **Ms. Whitmore** said that there is no ongoing collaboration. **Dr. Huang** added that the program is attempting to collaborate with Idaho State University and Boise State University, which have access to the IEN for education and outreach purposes.

Representative Rusche asked if the telemedicine program provides a proprietary, competitive advantage to St. Als, which may result in competing networks. **Dr. Huang** replied that the program does provide a competitive advantage. The model being developed will allow collaboration with entities such as the Rocky Mountain Poison Control Center to provide toxicology services and the University of Utah Burn Center to the Western region. **Ms. Whitmore** added that the services help standardize services regionally.

Representative Marriott asked why the malpractice insurers were limiting telemedicine practice to ten percent. **Dr. Huang** answered that the insurers do not, as yet, have a lot of experience with telemedicine and may have to revisit this limitation in the future. In response to **Representative Marriott's** follow-up question, **Dr. Huang** said that malpractice premiums have not gone up due to this program.

Mike Gwartney, Director of the Department of Administration, asked **Doug Dammrose**, M.D., Chief Medical Officer of Blue Cross of Idaho, to provide the task force with a report on the state of Idaho employee health plan. A copy of **Dr. Dammrose's** PowerPoint presentation is available at LSO and online at: www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare.htm.

Dr. Dammrose stated that there are 45,000 state of Idaho Consolidated Omnibus Budget Reconciliation Act (COBRA) members. There are a larger percentage of COBRA "Medicare in Training" state of Idaho members in the 50 to 54 and 55 to 59 age groups than in the total Blue Cross large group members. In the 2009 fiscal year, the total medical and prescription savings for the state of Idaho health insurance program was $118,833,285, broken down as follows: benefit enforcement - $30,098,384; contractual adjustment - $69,025,025 (almost all Idaho providers are under contract with Blue Cross); pharmacy network - $15,670,119; and averted costs - $4,039,757 (through case management). Cost containment has helped reduce medical costs from an estimated 11% to the actual 7.2%. The major contributor in cost increase has been the 72% increase due to malignancy claimants and their resultant 143.6% increase in costs. Hospital outpatient dialysis has also increased by

61%. The next steps to contain cost increases include: a three-tier formulary; increase generic prescription drug rate; oncology treatments possibly on a pay-for-performance basis; and improved dialysis contracts.

Mr. Gwartney added that the experience has been good. Reserves are lower than in the past, but in good shape. There are concerns regarding the swine flu.

Senator Cameron asked about encouraging used of the lower of the three tiers on prescriptions. He explained that the three tiers are: generic drugs; preferred name-brand drugs; and nonpreferred name-brand drugs. **Dr. Dammrose** replied that some state employees have chosen to stay with their previous, higher-tier medications. The goal is to ensure that disease outcomes are being addressed. Patient preference may be overridden by case management. **Senator Cameron** asked if there were any nonpreferred name-brand drugs without lower tier alternatives. **Dr. Dammrose** all have a lower tier available in the same class but the efficacy of moving to alternatives may result in appeals. In the event of a written appeal, Blue Cross requires objective medical evidence from the practitioner that the alternative is not as effective. **Senator Cameron** asked what incentives are being implemented to encourage the use of genetics. **Dr. Dammrose** replied that on some genetics, insureds are given six month prescriptions free of charge. There is also a pilot program regarding diabetic management to waive the co-pay for certain generics. This information is being communicated through letters. However, to participate in these lower cost options, the insured must establish an account and set up tracking tools.

Representative Collins asked about the cost savings through oncology management. While this is a challenging area, **Dr. Dammrose** felt that there is some opportunity to improve management in this area. In other localities chemotherapy generics have been used successfully. However, federal legislation has protected the patents of specialty biologic drugs for 13 years. Some savings may be achieved in the way cell stimulators are being used. The goal is to work with oncology clinicians to look at ways to improve efficiencies. Also, there is a need to do a better job in informing members regarding end-of-life alternatives that may not be effective to help in their decision making.

Senator Goedde asked how to get a better return on moneys through preventative care. **Dr. Dammrose** said that this is a tough question to answer. Smoking is a big risk factor, especially in regard to cancers, and effects accrue over many years. Obesity may now exceed smoking as a health cost factor, resulting in a high incidence of type II diabetes and kidney failure, requiring dialysis. Approximately 70% of our health care costs are attributable to things that could be prevented.

Senator Cameron commented that the health care reform legislation being considered at the national level calls for insurance plans to be qualified, including no co-pays on preventative care, no annual or lifetime limits and no deductibles. He asked if **Dr. Dammrose** had any judgment on how those qualifications would affect the state plan. **Dr. Dammrose** believes that these changes would not be financially viable and would bankrupt the state and the country.

Senator LeFavour asked if the cost to health providers and taxpayers of caring for the uninsured and preventative care measures are taken into consideration, would **Dr. Dammrose's** view regarding financial viability be affected. **Dr. Dammrose** stated that indigents receive only 40% of the care they would seek if such care was available to them. There is a high pent-up demand for health care. There is not enough money to pay for health care at the current rate. Under a government plan, there is

concern that the government would cover everyone and then cut the fees to the providers. The cost of care today is driven by the high cost of pharmaceuticals and imaging.

Mr. Gwartney was asked to update the task force regarding how part-time employees will be treated under the state health plan. He reported that he has been meeting with the constituents, including the universities, and the Department is on the verge of issuing guidelines. Exceptions regarding treatment of part-time employees will be made where necessary. He also met last week with the Mental Health Care Task Force and guidelines will be issued in the near future.

Senator Cameron excused **Representative Collins** from the task force's afternoon session and introduced **Cynthia York** as the new CAT Fund administrator, expressing the hope that **Ms. York** can present to the task force at its November 4th meeting regarding the developments at the CAT Fund following the changes made to that program by the Legislature last session.

Paul Leary, deputy administrator of the Division of Medicaid, Department of Health and Welfare, provided an update to the task force on federal approval of the state Medicaid plan. A copy of **Mr. Leary's** handout is available in the Legislative Services Office. **Mr. Leary** informed that the items listed on the handout colored in green have been approved, the yellow colored items are in the process of approval and the red items have been rejected. Rejected are: changing the pricing method for affiliated agencies, due to a pending lawsuit; and removal of a nonemergency transportation benefit for Medicaid Basic Plan participants, due to changed federal regulations. Some of the yellow items have been implemented pending approval. **Mr. Leary** stated that the state Medicaid plan is amended yearly and that the plan is effective upon submission. In response to **Senator Cameron**, **Mr. Leary** stated that the Department implements plan changes prior to federal approval only when it is comfortable that the change will be approved.

Senator Cameron asked if the reason the Katie Beckett program has not been submitted for federal approval is because it has not, as yet, been approved by the state. **Mr. Leary** stated that is correct. **Amy Johnson** informed the task force that the Department has revised the original rule on this matter. **Senator Cameron** requested that copies of that revised rule be sent out. Information regarding this rule change is contained in a letter to Legislators from **Leslie Clement**, Administrator of the Division of Medicaid, dated September 10, 2009. A copy of this letter is available in the Legislative Services Office.

Representative Carlos Bilbao asked whether a transportation broker has yet been chosen. **Mr. Leary** reported that the Department has been through the Request for Proposal process once on this matter, which was challenged on procedural grounds. The original bid was pulled back and is being resubmitted.

Representative Rusche asked how the holdbacks announced by the Governor last week will affect the Department. **Leslie Clement**, the administrator for the Division of Medicaid, stated that the Governor has given the Department priority with regard to budget reductions. The Department's recent reduction is 3.3% overall. The Department is moving ahead on the transportation broker matter and is employing utilization management, including prior authorization for imaging, as a way to control costs. **Senator Cameron** asked how the 3.3% holdback will affect the Medicaid program. **Ms. Clement** replied that while the Department is required to pay claims within 30 days, it will be able to push some payments into the next fiscal year. With $28 million in payments made each week, pushing the final

three payments in the current fiscal year into the next fiscal year will account for much of the holdback. **Representative Rusche** asked how the holdbacks will affect caseloads. **Ms. Clement** answered that Idaho has restricted eligibility requirements in place already. The Department has experienced an increase in the utilization of Basic Plan program within the 133% to 185% Federal Poverty Level group. There was a four percent increase in caseload in fiscal year 2009, and the Department is projecting that percentage being doubled in fiscal year 2010. Some parents will become eligible for Medicaid as their children become eligible for the Children Health Insurance Program, but not on a one-to-one ratio.

Senator Cameron commented that the Governor calculated a $175 million shortfall. Other sources of funds are making the shortfall at around $153 million. If the holdback was applied evenly, it would have resulted in a six percent across-the-board reduction. The Governor has bifurcated the reduction with four percent being imposed now and with more forthcoming. The revenue model is based on the last six months of the fiscal year, four of which came in better than the previous year. The current holdback may not be the last.

Former state **Senator Dick Compton**, the chairman of the Idaho Health Data Exchange (IHDE), came before the task force to request support in the IHDE's grant application to the National Coordinator for Health Information Technology. A copy of the IHDE's letter of intent to apply for the grant is available in the Legislative Services Office.

The IHDE is the work product of Idaho's Health Quality Planning Commission, created by the Legislature in 2006, to promote improved quality of care and health outcomes through investment of health information technology in Idaho. The IHDE was established in 2008 by the Commission to develop and implement the Commission's plan to achieve that goal. The IHDE received $500,000 from the state and an additional $1.6 million from Blue Cross of Idaho and Regence BlueShield of Idaho as start-up moneys and is financially viable. The IHDE has hired an executive director, **LaDonna Larson**, and has selected Axoloti Corporation as its technology vender. The IHDE has a five-year plan to electronically connect more than 1,500 Idaho physicians, 30 hospitals and ten ancillary service providers across the state. **Senator Compton** reported that the system works fine, although there have been some minor setbacks due to personnel changes without appropriate transfers of knowledge and legal reviews.

Senator Compton informed that the IHDE is eligible for a $5.29 million federal stimulus moneys grant. The deadline for the grant is October 15th. The IHDE should know the outcome of its application by February 2010. The work of the IHDE is important to help reduce health care costs and to improve cooperation between doctors and hospitals. **Senator Compton** requested that the task force send a letter of support of the IHDE grant application.

Representative Rusche moved that the task force authorize its chairmen to draft and send a letter to the National Coordinator for Health Information Technology in support of the IHDE grant application. Representative Sharon Block seconded the motion. In discussion on the motion **Senator LeFavour** asked if the IHDE would distribute the stimulus moneys it is applying for to others or whether it would spend these moneys itself. **Senator Compton** said there was still a question as to whether the IHDE would receive these funds directly or whether the moneys would be administered by the Department of Health and Welfare. The moneys would be used to tie 30 of the critical care hospitals together. Initial fees would be charged to the hospitals, although the IHDE may help pay that fee. **Representative Marriott** asked if there would need to be subsequent state appropriations once the

grant moneys are spent. **Senator Compton** replied that the IHDE would be self-sustaining through fees. **The motion carried unanimously.**

Senator Broadsword addressed the task force on the issue of insurance coverage for orally administered chemo treatments for cancer. She presented a letter to the task force, a copy of which is available in the Legislative Services Office. **Senator Broadsword** stated that cancer is bad enough without the threat of bankruptcy. Insurance policies treat oral cancer treatments like prescriptions, with co-pay, co-insurance, out-of-pocket limits and annual and lifetime maximums. **Phillip Role, M.D**., who was scheduled to present to the task force on this issue was unable to attend due to reoccurrence of his cancer. The issue is the method of delivery. If delivered intravenously (IV), the insurance companies treat it as a medical benefit; if delivered orally, the insurance companies treat it as a prescription benefit. Appealing the insurance company's decision to apply the prescription drug benefit, rather than the medical benefit, for these orally administered treatments may be successful, but results in delays. As a result, treatment choice is sometimes based on coverage rather than on effectiveness. Although this same issue may arise with other diseases, cancer is different. **Senator Broadsword** introduced **Christian Shull, M.D**. to the task force.

Dr. Shull stated that the science of oncology has outstripped the contractual basis for payment. More treatments are moving towards oral administration. Not only does this result in differing benefit requirements and restriction but may require persons living considerable distance from a hospital to make multiple trips to receive the IV when the medicine could be taken orally at home. Some drugs are only available orally. Cancer is about urgency. Appeals may result in delays and serve as a barrier. **Dr. Shull** stated that the Idaho Medical Association passed a resolution calling for treatment on an equitable basis, regardless of the means of administration.

Senator Stegner asked if the oral or IV medications are identical in efficacy. **Dr. Shull** replied that with regard to rectal cancer, yes – both meet the standard of care.

Senator Cameron stated that insurance plans vary regarding medical services and prescription drug benefits with regard to co-pays, co-insurance, deductibles, out-of-pocket limits and annual and lifetime caps. He asked how the legislation proposed by **Senator Broadsword** would address coverage in the same way. **Senator Broadsword** stated that there would be parity for treatment, no matter the form of delivery, if chemotherapy was treated as a major medical expense. **Dr. Shull** added that legislation could be crafted stating that oral chemotherapy is to be covered no less favorably than medicines administered via IV.

Representative Marriott asked if orally administered chemotherapy is equal in cost to that administered through IV. With regard to rectal cancer, **Dr. Shull** stated that the answer is "yes." With other cancers, the oral medicine may be more expensive. However, the cost of administering the IV must also be taken into consideration. **Senator Broadsword** stated that the information shows cost comparability.

Representative Rusche commented that when he was a medical director, he was under a contractual obligation to pay for the least costly therapy. **Senator Broadsword** stated that the requirement should be for payment of the cheapest of equally effective treatments. When orally administered treatments are the best practice, that treatment should be covered.

Senator Cameron stated that there remains still the co-pay, co-insurance and deductible, even with regard to major medical coverage. **Dr. Shull** stated that the biggest problem is the co-share arrangement and noted that chemotherapy is often the last treatment choice. By the time chemotherapy is employed, the patient has paid the major medical deductible and has reached the out-of-pocket maximum.

Richard Rainey, M.D., Idaho Medical Director for Regence BlueShield of Idaho, responded to the presentations by **Senator Broadsword** and **Dr. Shull**. **Dr. Rainey** stated that Regence agrees that patients should not be burdened with treatment options due to plan design. While other conditions have this issue, cancer has the highest mortality rates, but other patients suffer as well. Some insurance products have limited coverage for orally administered medications. This limited coverage was developed to same cost and make insurance more affordable. Regence provides coverage pursuant to its contractual obligations. Alternative benefits are available when not covered under the policy after evaluation that considers whether the treatment is medically necessary and reduces overall costs. Oral chemotherapy goes through this process.

Dr. Rainey noted that Oregon passed similar legislation to what is being proposed in Idaho and experienced unintended consequences of the interpretation of the phrase "no less favorable." That was interpreted differently among the plans. More specific language would not solve the problem, given that new oral medicine treatments are being developed.

According **to Dr. Rainey**, Regence is being proactive due to the introduction of new oral medications. New benefit designs with extended formularies for both oral and IV administered medicines are being developed. These new products will be marketed in the near future. The older products will treat oral chemo treatment as an alternative benefit.

Dr. Dammrose, on behalf of Blue Cross of Idaho, agreed that oral chemotherapy is a difficult problem. One of the two cases described by **Senator Broadsword** had self-insured group coverage. Self-insured group contracts must be enforced pursuant to their terms and are exempt from state legislation. The goal of Blue Cross is to follow the best science. The low-cost insurance products often do not have a pharmaceutical benefit. **Dr. Dammrose** has reviewed 80 cases where oral chemotherapy treatment was at issue. Some of these cases involved policies that did not have a pharmacy benefit. However, they were treated as a medical benefit through case management. Oncology costs have increased 200% over the past three years. The dollars have to come from somewhere. An integrated approach is needed. A mandate on insurance companies to provide oral chemo treatment coverage will result in unintended consequences.

Senator Cameron commented that the medications today may have gotten past our former procedures. It appears in many cases that the insurance companies are already pricing a product to cover chemotherapy under an IV. **Senator Cameron** asked why oral chemotherapy could not be covered under that same pricing methodology. **Dr. Dammrose** stated that was the logic used by the actuary. **Senator Cameron** asked why then, absent a mandate, the insurance companies could treat oral and IV administered chemotherapy under the same methodology without requiring an appeal. **Dr. Dammrose** said that when Blue Cross gets prior authorization of a drug that is more that $500 or $1,000 per dose, it automatically treats it as a major medical benefit in order to manage an inadequate benefit. Based on the testimony before the task force, **Senator Cameron** stated that there appears to be a gap in

how this matter is handled by the insurance companies. **Dr. Dammrose** reminded that 50% of the coverage is through self-insured groups that cannot be regulated by the state.

Senator LeFavour stated that there is a sense of urgency in protecting people from being forced into bankruptcy. She asked that in addition to the 80 cases where oral chemotherapy was covered, how many additional cases were not covered. **Dr. Dammrose** replied that 80 was the number of cases where coverage was requested. He could not find a denial unless there were extenuating circumstances, such as being in a self-insured group. Blue Cross has a good, expedited internal appeal process that can be completed within 72 hours, unless there are extenuating circumstances.

Senator Goedde asked **Dr. Rainey** to respond to the issue of denials. **Dr. Rainey** stated that he is aware of only one denial. **Senator Stegner** asked whether there is no coverage afforded if an appeal is not made. **Dr. Rainey** replied that he had not gone through the data to determine the answer to that question.

Senator Cameron asked if the American Cancer Society had an estimate for how many individuals have been affected by this issue. **Heidi Low** responded that, based on antidotal evidence, many are falling through the cracks. She added that doctors are changing the way they prescribe due to this issue.

Dr Shull commented that if the insurance companies are providing coverage in the end, then the review process is just a barrier. Why not provide coverage upfront without requiring an appeal? **Senator Cameron** responded that if a determination has to be made regarding the most efficacious and cost-effective means of delivery, then there must be a review in any event. **Dr. Shull** replied that insurance companies tend to approve drugs in a class for a certain condition, without specifying which in the class must be used. He suggested that the insurance companies could include oral chemo drugs within the approved class.

Senator Stegner asked how Medicaid treats this issue. **Dr. Shull** replied that Medicaid has a nice pharmacy benefit.

In response to **Dr. Shull's** comments, **Dr. Dammrose** stated that historically there was just a medical benefit. Pharmacy benefits were added subsequently, but are paid on a different platform. When an issue arises, the hard coded system treats these benefits separately. Therefore, a review is necessary to merge these benefits together. Blue Cross is doing a good job in meeting the needs of its members.

Senator Cameron concluded that this issue may have to come back before the task force and asked what additional information might the task force members want to be presented.

- **Representative Rusche** stated that he would like to see how big an issue this is and what have been the results in Oregon which adopted a mandate. Regence may get this information. He also would like to know the patient base for oral chemotherapy.
- **Senator Cameron** asked to be provided information on how many individuals are being denied, and why, by categories.
- **Amy Johnson** suggested that information on how Medicaid and the CAT Fund are addressing this issue may be informative.

- **Senator LeFavour** asked to have information regarding how this issue has been addressed legislatively in other states.
- **Representative Block** asked how patients are informed regarding the appeals process.
- **Senator Goedde** asked if **Senator Broadsword** could check to determine if the examples that she cited involved traditional or self-insured group plans.

Senator Cameron explained that on the back of each policy there is an explanation of benefits that set forth the appeal rights. He conceded that understanding and exercising those appeal rights may require some sophistication. He noted that the task force has pushed the insurance companies to provide more affordable health insurance products. These limited benefit policies have proven popular but, by their terms, have limited pharmaceutical benefits. Consumers, having made their choice, may be faced with the lack of coverage down the road when health problems occur. **Dr. Shull** added that when people purchase a limited benefit policy, they do not understand that oral chemotherapy is not covered as a medical benefit. The legislative process can be used to help protect these people.

Joy Wilson from the National Conference of State Legislatures updated the task force via conference call on the current status of the federal health care reform legislation. **Ms. Wilson** informed that the three bills in the House of Representatives are to be combined into one bill. At this point, it is unclear whether the House will bring its bill to the floor before the Senate begins acting on its bill. In the Senate, the leadership and the While House will bring the Health Committee and the Finance Committee bills together. She is not sure how this bill will be brought to the floor.

Changes to the Senate Finance Committee include: increasing subsidies for low-income individuals obtaining insurance through the exchange; increasing state assistance; providing a catastrophic option for the "young invincible"; reducing penalties for not obtaining insurance; and allowing a state opt-out if the state can accomplish the same goals and coverage requirements. According to **Ms. Wilson**, there are not sufficient votes in the Finance Committee for the public option. The Finance Committee bill would allow interstate compacts to permit selling of insurance products across state lines, has state-based incentives, and grants power to the National Association of Insurance Commissioners to develop standards. An attempt to amend the bill to remove the individual mandate failed.

Ms. Wilson provided task force members with a handout describing how the Senate Finance bill would affect the Medicaid program in Idaho. The handout is available in the Legislative Services Office and online at: www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare.htm. Under this bill, the CHIP program would end in 2013. Families covered by CHIP would either go into Medicaid or into the exchange. If in the exchange, Idaho would wrap around benefits not provided in the insurance plan. The federal government would match this cost at the enhanced CHIP match rate. The CHIP wrap-around cost to Idaho would increase 1.5% over the ten-year period. Idaho would get a 95% match rate for new Medicaid participants at or below 133% of the FPL for five years. **Ms. Wilson** does not know what would happen after five years. The information provided to **Ms. Wilson** indicates that Idaho Medicaid spending would go down eight percent in the first three years but would increase 1.9% in the ten-year period. She was unable to explain the three-year decrease.

Senator McGee asked who would determine if a state is meeting the required goals if it exercises the opt-out option. **Ms. Wilson** responded that the Senate Finance Committee is marking up a concept paper that lacks details. Once the concept paper is marked up, the legislative council drafts the

corresponding legislation. She will look in the concept paper to see if the information required to answer **Senator McGee's** question is in there.

Senator Cameron commented that the representation has been made that people will not be forced to drop existing coverage under the proposed health care reform legislation, but the proposed legislation requires that plans meet qualification standards and that no current Idaho plan would qualify. If the plan did not qualify, the policyholder would be forced to drop the policy or pay a penalty. **Ms. Wilson** agreed that ultimately all plans would have to come into compliance after a transition time. She added that currently no one is guaranteed existing coverage due to the annual open season when the terms of a policy can be changed. She stated that people could hold onto an individual policy or opt to a cheaper exchange product.

Representative Rusche stated that regarding the current federal legislation, he has not heard the issue of health care delivery addressed to a great extent. **Ms. Wilson** replied that most of the health care delivery provisions deal with Medicare and deal with care management, nonpayment to hospitals for infections suffered by patients while another condition is being treated, wellness provisions, and comparative effectiveness provisions, although there is a dispute as to what "effectiveness" means.

Representative Fred Wood asked **Ms. Wilson** to give an assessment as to whether health care reform will pass the Congress**. Ms. Wilson** replied that her current assessment has risen from 50/50 to 55/45. The Senate has potentially 60 votes; no one is walking away and the Republicans are offering amendments. The existing bills need to be reduced to one House and one Senate bill before **Ms. Wilson** is willing to revise these odds.

Senator Cameron asked whether the House will pass whatever bill that comes out of the Senate. **Ms. Wilson** responded that everyone is waiting to see what comes out of the Senate and whether the Senate Democrats will hold together. Sixty votes are needed in the Senate to avoid a filibuster, since the Senate is not treating health care reform under the reconciliation process.

Senator Cameron asked how the Medicare Advantage program is being treated in the proposed legislation. **Ms. Wilson** replied that Medicare Advantage has bipartisan support but may be reduced in its reimbursement provisions. She added that seniors are an important constituency.

Senator Goedde asked what the time gap is between the publishing of a bill and a vote. **Ms. Wilson** stated that there is a two-day minimum, unless waived by unanimous consent. Usually, the first amendment to a bill is the technical correction offered by the committee chairman. **Senator Cameron** inquired whether the Congress will be finished with health care reform by November 4th. **Ms. Wilson** said "no."

Representatives of stakeholders in the health care reform debate were asked to present their views to the task force.

Susie Pouliot, chief executive officer of the Idaho Medical Association (IMA), provided a handout to the task force on the Association's policy on health care reform, adopted by its House of Delegates on July 26, 2009. A copy of this document is available in the Legislative Services Office. The IMA supports health care reform that meets specified criteria that: improves the health care system through expansion of health care access; improves quality care; reforms government programs; reduces

cost; increases focus on wellness and prevention; reforms payment and delivery systems; and increases patient access by reducing physician workforce shortages. **Ms. Pouliot** stated that the IMA adopted a resolution two years ago supporting universal access to care for all Idahoans, though not necessarily through a single payer system. A majority of the IMA members do not support a public option. The IMA does support bolstering reimbursement for primary care physicians. Regarding reducing costs, **Ms. Pouliot** thanked the Idaho Legislature for adopting tort reform legislation that has resulted in Idaho having one of the lowest malpractice premium rates in the country. The physicians think it is important to: encourage reasonable and sustainable pharmaceutical pricing with industry accountability; utilization of the medical home concept; relax antitrust laws with regard to hospital management; and reform of the health care delivery system.

Steve Millard, president and chief executive director of the Idaho Hospital Association, stated that the American Hospital Association (AMA) rests its position on five pillars: coverage for all, paid for by all; the most efficient, affordable care; highest quality; best information, including electronic record keeping; and keeping people healthy and not fixing them after they get sick. The only proposal that come even close to covering the five pillars is the Senate Finance Committee proposal. The AMA made a deal with the Senate Finance Committee to forego $155 million over ten years in Medicare reimbursement to hospitals in the belief that having more insured people coming to hospitals will recover that amount. The AMA is opposed to the public option and its Medicare rate structure. Incentives need to be changed. Currently, providers are paid to do more on a fee for service basis. Although it is difficult to get away from past, established practices, unnecessary readmission should be penalized and reimbursements should be bundled. We needed to change the delivery system in addition to insurance reform.

Dr. Dammrose, representing the Idaho Association of Health Care Plans, stated the insurance industry needs to be restructured, coverage should be affordable and available to all and that preexisting conditions should not prohibit access to insurance. To accomplish these things, an effective mandate is required with reasonable premium rates. People should not be allowed to jump in and out of insurance. Consumer choice in a competitive market is an important aspect of any solution. People should be rewarded for healthy behaviors. There is opportunity to reduce waste and redundancy by bundling payment to providers for services, coordinating care, eliminating the variation in care that is not evidence based with head-to-head comparison of what really works, and reducing administrative costs by increasing efficiencies.

Dede Shelton, advocacy director for AARP Idaho, provided the task force with a handout, which is available in the Legislative Services Office. She told the task force that most seniors want to stay home and that home and community-based health care services that will reduce costs should be expanded, with transitional care benefits. Her organization supports improving technology for keeping and sharing health care records. Nursing and primary care physician incentives need to be encouraged. Fraud and abuse in state health care services needs to be reduced, including over-billing and double billing of charges. Also, preexisting condition restrictions need to be eliminated and the gap on age ratings needs to be closed. The "doughnut hole" for prescription drugs under Medicare needs to be closed. Doctors should be allowed to make health care decisions. The proposed national legislation includes many factors that the AARP views as priorities.

Alex LaBeau, president of the Idaho Association of Commerce & Industry, said that his organization represents hospitals, insurance companies, drug manufacturers and retailers, and other

health care service providers. The concern is with how the proposed legislation will affect the benefit packages offered employees. The health care industry is an industry. The difference is that nobody chooses to get sick, so the health care industry is not a true market. We have to be careful about mandates. The United States has the best health care in the world in terms of quality of care. Everyone has access to health care; not everybody has access to insurance. The Health Insurance Portability and Accountability Act dramatically increased administrative costs but did not improve health care. Savings may be achieved by changing the way providers are reimbursed, reducing malpractice litigation that results in the practice of defensive medicine, increasing transparency in the system through consumer evaluations and comparison ratings, reducing mandates and providing more options for health insurance, and incentivizing healthy lifestyles. **Mr. LaBeau** concluded that it is an expensive system. We need to look at the reimbursement process related to outcomes and encourage primary care.

Steven Ricks, representing the Idaho Chamber Alliance, posed a number of policy questions regarding health care to the task force. Answering those questions, **Mr. Ricks** proposed that: there should be a tax credit on health insurance payments; there should a workman compensation type of system for handling medical negligence malpractice type claims; health insurance should be available interstate; and mammoth expansion of government intervention in the health care system should be rejected.

Tom Shores and **Scott Leavitt** addressed the task force on behalf of the Idaho Association of Health Underwriters. **Mr. Shores** stated that each family pays over $1,000 a year for cost shifting resulting from Medicare and Medicaid. Co-pays should be added to Medicaid to reduce that cost shift. Most health insurance in Idaho is prepaid medical plans, not truly health insurance. Perhaps some version of the British system requiring the loser to pay in tort cases should be adopted. **Mr. Leavitt** addressed health care costs. To reduce health care costs and make the system more affordable, the following should be addressed: medical internet technology, include electronic medical records; medical transparency allowing consumers to be smarter about health care; wellness programs; consumer outreach programs to help people know when to receive medical care; and tax credits for those earning under $50,000 to encourage the purchase of health insurance. **Mr. Leavitt** stated that his group is against the public option and employer mandates. He is skeptical of representations regarding keeping essential benefit packages under proposed federal legislation.

Senator Cameron stated that at the task force's next meeting, additional groups should be added to the panel. A number of follow-up questions need to be addressed by the panel members: should Idaho opt in or opt out of a national health care reform program, and if Idaho opted out, what would an Idaho program look like; and should a constitutional provision be considered by Idaho that prohibits a public option such as in Arizona.

Senator Cameron reminded the task force that the next meeting is scheduled for November 4th. Task force members need to get their calendars to Legislative Services regarding availability for a task force meeting in early December. If task force members have agenda items, they need to contact the co-chairs.

The meeting adjourned at 4:06 p.m.