MINUTES

(Approved by the Task Force)

HEALTH CARE TASK FORCE

Boise, Idaho
November 4, 2009

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 present were Paige Alan Parker, Amy Johnson and Charmi Arregui.

Panel members were: **Susie Pouliot**, Idaho Medical Association; **Steve Millard**, Executive Director, Idaho Hospital Association; **Steve Thomas**, Idaho Association of Health Plans; **David Irwin**, Communications Director, AARP, Idaho; **Alex LaBeau**, President, Idaho Association of Commerce & Industry; **Tom Shores** and **Scott Leavitt**, Idaho Association of Health Underwriters; **Denise Chuckovich**, Executive Director, Idaho Primary Care Association; **Heidi Low**, American Cancer Society and Cancer Action Network; **Suzanne Budge**, National Federation of Independent Businesses; and **Cameron Arial**, Zions Bank & Idaho Chambers of Commerce.

Others attendees were: Richard Rainey, M.D., Idaho Medical Director, Regence BlueShield of Idaho; Russ Duke, Director of Public Health District No. 4; Woody Richards, Blue Cross of Idaho; Benjamin Davenport, Risch Pisca, PLLC; Sara Stover, Division of Financial Management; Kathie Garrett, Partners in Crisis; Martin Bilbao, Connolly & Smyser, Chartered; Tony Poinelli, Idaho Association of Counties; Joie McGarvin, American's Health Insurance Plans; Kris Ellis, Benton, Ellis & Associates; Colby Cameron, Sullivan & Reberger; Dick Armstrong, Dick Schultz, Cynthia York, Leslie Clement and Paul Leary, Department of Health and Welfare (DHW); Amy Holly, Business Psychology Associates; Bill Deal, Director, Department of Insurance; Brad Huerta, Portneuf Medical Center, Pocatello; Jon Smith, The Hospital Cooperative; McKinsey Miller, Gallatin PA; Elizabeth Criner, Veritas Advisors, LLP; Corey Surber, St. Alphonsus; Celinda Snyder, IPCA; Dan Heincy, Merck Sharp & Dohme Corp.; John Watts, Veritas Advisors; Sharon Fisher, AARP; Representative Phylis King; Carla Terry, IHA; Robert Luce, Attorney General's Office; Shaun Menchaca, Portneuf Health Care Foundation, Pocatello; Bill Roden, Delta Dental; Julie Robinson, Family Medicine; Paul Nielsen, MedImmune; Michele Sherrer, Gem County; Don Stecher, Novartis; Betsy Russell, The Spokesman-Review; Megan Ronk, Idaho Meth Project; Samantha Wright, NPR News; Mike

Brassey, Gary Krouth and Jeff Cilek, St. Lukes; Joan Krosch, Department of Insurance; Dustin Hurst, Idaho Freedom Foundation; Fred Turner; and Joy Wilson, National Conference of State Legislatures (by conference call).

Co-chair Representative Gary Collins called the meeting to order at 10:10 a.m.

Representative Bilbao moved that the minutes from the September 28, 2009 meeting be approved with one small correction, seconded by Senator Lodge, and the minutes were approved unanimously by voice vote.

Senator Joe Stegner reported to the task force on the Mental Health Subcommittee saying that there has not been any significant development on the Western Interstate Conference for Higher Education (WICHE) plan to transform Idaho's mental health program being undertaken by Governor Otter's Mental Health Transformation Work Group. That work group is proceeding with a competitive bid process for a contract to assist it in the implementation of the transformation. The work group is making progress and is being effective. **Senator Stegner** reported that the time frame for that effort is being moved back; realistically it was hoped to have that completed during the 2010 Legislative Session for review, but that is looking less likely, delayed perhaps until late spring, 2010. He said this was disappointing, predictable and inevitable due to economic concerns in the state. **Senator Stegner** and **Representative Block**, Co-chairs of the Mental Health Subcommittee, will continue to attend the Governor's work group to monitor that progress.

Senator Cameron reported on the Immunization Subcommittee held just prior to this meeting; those minutes are on our legislative website at:
http://www.legislature.idaho.gov/sessioninfo/2009/interim/immunizations1104min.pdf

Senator Cameron commented that the vaccine selection process for the universal select program is being reviewed. A seven-state comparison was presented by **Ted Epperly, M.D.** and **Russ Duke**, Director of Public Health District No. 4, on vaccine selection, with potential recommendations. Two handouts from the previous meeting were given to the task force members: "Department of Insurance Agency Profile - Premium Tax Distribution;" and "Chip B, Children's Access and Adult Access Insurance Premium Tax Fund Projection - Fund 0173 - State Fiscal Years 2005-2012." These handouts are available in LSO. The subcommittee heard from **Ms. Amy Johnson**, Principal Budget and Policy Analyst, Legislative Services Office (LSO), who had informed the subcommittee that the premium tax is declining much more rapidly than anticipated, due to few policies being sold. The projection provided by **Ms. Johnson** is that in 2011 there will be no money for the Access Card and the amount for the High Risk Pool may be cut in half from $5.3 million in 2008 to $2.4 million. Under these circumstances, for the first time money from the Adult Access Card will have to be directed to the Children's Access Card.

Senator Cameron said this presents a quandary since there are no general state funds to continue immunizations beyond January 30, 2010. A round table discussion on the Idaho Immunization Program's alternatives and funding also took place. The Immunization Subcommittee will meet again on November 30.

Representative Rusche inquired if it would be reasonable to ask insurance companies for a voluntary contribution until the next fiscal year to buy some time since these companies benefit from reduced vaccine costs. **Senator Cameron** said that all options will be explored prior to and at the next meeting; $4.3 million is the amount needed.

Representative Collins invited **Ms. Johnson** to explore options and perhaps make recommendations prior to the next meeting.

Ms. Cynthia York, Medically Indigent Services Program Administrator, Department of Health and Welfare (DHW), provided a handout to the task force titled, "Update of the Requirements of SB1158 Medically Indigent Program." Her presentation is available in LSO. **Ms. York** works with the Idaho Association of Counties (IAC), Idaho Hospital Association (IHA), Idaho Medical Association (IMA), and the board of the Catastrophic Health Care Cost (CAT) Program to facilitate the process that addresses requirements of SB 1158 (2009). Those requirements include:

- Develop a uniform application;
- Design and create a utilization management program;
- Address a third-party recovery system;
- Engage contractors to perform those functions;
- Implement a Medicaid eligibility determination process for the Medically Indigent program.

Ms. York said that her first order of business upon joining DHW was to develop a steering committee, which first met on August 12, 2009. The steering committee looked at the requirements of SB 1158 as "products" or "deliverables" defined as follows:

1. Uniform or Common Application Form
2. Utilization/Medical Management
3. Third Party Recovery/Collections
4. Cost Allocation
5. Rules

Ms. York said that two workgroups were established to address the Common Application Form and Utilization/Medical Management. Workgroup members were selected from Idaho's smaller, more rural areas as well as more populated regions.

Ms. York said the Common Application Form workgroup is on target to have the combined application form implemented by July 1, 2010. This workgroup is not just looking at combining the County Application Form and the Medicaid Application Form, but also examining and agreeing to the processes that have the potential to provide savings. By mid-January, this workgroup will submit a draft of the Combined Application Form to the Steering Committee. Upon approval, the form will be presented to the IAC and IHA. Pilot testing will take place in March and training for the Indigent Directors and hospitals is scheduled for April. A phase-in process will be implemented in May and June with full implementation targeted for July 1, 2010.

The Utilization/Medical Management workgroup is in the process of sending out a Request for Information (RFI) to firms that perform the spectrum of claims management. The RFI is scheduled to go out late this month. After reviewing the responses to the RFI, the steering committee will prepare a Request for Proposal (RFP) to be released in January. A contractor could be selected in April and a contract could potentially be awarded the first part of June, with a July 1, 2010 implementation date.

Ms. York said one of the challenges the steering committee faces is the lack of data or information from which to base a budget request for 2011. The budget figure will depend on estimating the number of claims. **Ms. York** said she intends to have an estimate of the scope of services and cost for those services by early January.

Senator LeFavour inquired if **Ms. York** had addressed the automatic lien provision applied at time of application for indigent services and noted that other states apply a lien only if there is non-payment; she believes that Idaho is alone in applying a lien upon application. Senator LeFavour stated that the immediate imposition of the lien negatively impacts credit. **Ms. York** said the focus has been mostly on claims payment but, as things go forward, this will be examined. **Ms. York** invited **Tony Poinelli**, Deputy Director of the Idaho Association of Counties, to answer that question.

Mr. Poinelli responded that **Senator LeFavour**'s concern has been discussed because it boils down to responsibility. The lien issue, he believes, has not caused major problems, adding that counties are not trying to force people out of homes. He confirmed that the lien provides an incentive for payment. The counties have accommodated homeowners needing to refinance who have a good payment record by releasing the lien and then reattaching it once the refinancing has been completed. **Senator LeFavour** responded that her gravest concern is impact to people's credit and their ability to rearrange financing to make payment; she advised studying that. **Mr. Poinelli** acknowledged it would be good to look at this.

Representative Block inquired about the economy causing counties to encounter more indigent people than planned on and wondered what effect this might be having on budgets. **Mr. Poinelli** answered that the counties did plan on the increase in the CAT Program deductible, but the number of cases has grown from 1,100/year average over a 3-year period to 1,400-1,500 this past year, which has definitely impacted all budgets. He said that many counties are issuing across-the-board holdbacks and that budgets are severely in crisis.

Representative Rusche said one big issue is trying to determine who is eligible and how to modify the level of care being provided before it is determined. He asked if there was any way of estimating cases that the CAT Program sees, wondering how many get rejected after application. **Mr. Poinelli** said that data he has could be provided to the task force but is about a year old. He estimated that about 40%-45% of application claims are approved and 55%-60% are denied. He affirmed that counties deny claims based on circumstances, such as potential Medicaid coverage and non-cooperation, lack of information and the availability of resources. He pointed out that Medicaid also denies claims for some of the same reasons.

Director Debbie Field, Office of Drug Policy, handed out to the task force a packet on the Idaho Meth Project and an Idaho Office of Drug Policy Report dated November, 2009 (available in LSO). **Director Field** shared that everyone could be proud of the Idaho drug policy. She reported that in FY 2009 across all populations, 15,263 Idahoans received services for substance use disorder treatment, which represents a significant increase. This 15,263 figure includes: Total non-criminal justice population count treated - 3,430; total felony population treated - 4,754; total misdemeanor treated - 3,726; total adult drug court participation - 1,359; criminal justice pregnant women and women with children - 165; and total adolescents - 1,823. The Office of Drug Policy manages people in treatment on a monthly or weekly basis, striving to not duplicate efforts with other agencies and sharing information. **Director Field** presented a "Budget Snapshot for FY 2010" (available in LSO).

Director Field explained the process of client-protected assessments, web-based as of July 1st, in order to collect data for reports. The statewide approach to assessing needs and establishing accountability standards throughout the system has placed Idaho as a leader in the nation for this achievement. **Director Field** updated the task force on the many projects of the Office of Drug Policy including: budget analysis and review of agencies who deliver substance use disorder treatment services; a population management process for planning the most effective means to deliver and monitor treatment expenditures; cost/benefit analysis to measure results of current treatment expenditures on the criminal justice population; a state contract for drug testing in coming months; a DUI evaluation process redesign; screening tools at the county level; a coroner toolkit for deaths involving alcohol; strategic prevention planning; and pharmaceutical waste disposal planning. She talked about the prevention success of the Idaho Meth Project, emphasizing that no adolescent had gone into drug court this year with meth as drug of choice, which is very significant. **Director Field** reported that phase 3 of the Idaho Meth Project will begin in January, 2010, which focuses on what meth does to relationships. Meth use has dropped significantly since the Idaho Meth Project began with over 800 volunteers working across the state, as well as the ad campaign. **Director Field** said that the Office of Drug Policy is treating maximum participants with 1,300 people on a wait list, and are doing everything possible to get this wait list decreased.

Representative Block thanked **Director Field** for making such a difference in drug policy and treatment in Idaho and announced that **Director Field** received the 2009 President's Award from the National Association of Alcoholism and Drug Abuse Counselors (NAADAC, the Association for Addiction Professionals) for her work in substance abuse treatment and prevention. **Director Field** expressed shock at receiving this award and accepted it on behalf of Idaho and for everyone

who had participated over the last 2 ½ years since the Office of Drug Policy began.

Representative Block asked for more information on the new Family Drug Court. **Director Field** answered that there are several pilot projects in Pocatello and Magic Valley; she will get that information for the task force, but confirmed that significant change is happening with families participating in the Family Drug Court.

Representative Rusche commended **Director Field** and the Office of Drug Policy for their work. He noted the 1,300 persons on the waiting list for services and inquired how many people on that list have private insurance and the interaction with private insurance, providers and the Office of Drug Policy. **Director Field** answered there is no wait list for people with private insurance. Medicaid covers adolescents, pregnant women and women with children and pays 80 percent, so all who are Medicaid eligible are being treated. **Representative Rusche** asked if most health insurance plans have adequate substance abuse and mental health coverage. **Director Field** responded "no," and that more work is needed.

Director Field stated that the Office of Drug Policy is working across all populations including drug court regarding sliding fee scale and treatment reimbursement or pay back. **Senator Lodge** said that success is wonderful, and encouraged continuation of paying back for treatment received on a sliding fee scale.

Dr. Christine Hahn, Office of Epidemiology & Food Protection, Division of Public Health, DHW, handed out "Idaho H1N1 Vaccination Update" (available in LSO) and announced that DHW has redesigned its website to include vaccination information at: **http://www.healthandwelfare.idaho.gov/** .

Dr. Hahn said that some private providers are getting H1N1 vaccine, but most of vaccine is administered at the public health clinics. **Dr. Hahn** showed a chart listing the four different manufacturers of the H1N1 vaccine by vaccine type, presentation, preservatives and age groups for which indicated. **Dr. Hahn** said the initial target groups for the H1N1 vaccination are: pregnant women; caretakers of infants less than 6 months; children and young adults age 6 months through 24 years; adults age 25-64 years with medical conditions putting them at high risk of flu complications; and healthcare workers and emergency medical service providers. **Dr. Hahn** shared reported hospitalized influenza cases in Idaho by age, as of October 29, 2009. She said the Centers for Disease Control (CDC) is providing H1N1 vaccine free to states. Vaccine is allocated several times per week and is ordered by the Division of Health the same day it's made available. The vaccine is sent directly from distributors to hospitals, community health clinics, and local public health districts. Hospitals and community health centers will be allowed to begin placing orders for additional vaccine this week, but may not receive all that is ordered, based on supply. **Dr. Hahn** said that as of November 2, 2009, 158,300 total does of H1N1 doses had been distributed by Idaho DHW; she referred to a graph, showing a general increase in the weekly number of vaccine doses allocated/ordered for Idaho. Normally, about one-third of Idahoans receive seasonal flu vaccinations, and to date the number of H1N1 vaccinations is not nearly at one-third.

Senator Stegner asked why infants 0 to 6 months are not receiving H1N1 vaccinations. **Dr.**

Hahn said that young infants do not have a fully developed immune system. Studies have shown that young infants don't form a good antibody response to vaccines, so caretakers of infants should be vaccinated to protect infants. **Senator Stegner** asked about a possible shortage of regular flu vaccine in the state. **Dr. Hahn** answered that manufacturers had over-promised what they could deliver. **Senator Stegner** asked about availability of seasonal flu vaccine in the near future. **Dr. Hahn** said that by mid-November and December, there should be plenty of seasonal and H1N1 vaccine, but one never knows until it arrives. She cautioned that the peak flu season normally is in February.

Representative Rusche pointed out some school closures due to flu outbreaks, asking about any significant disruptions in businesses in the private sector. **Dr. Hahn** said she was not aware of any major disruptions, but that there were more sick people than usual. The schools have done a good job staying open, especially compared to last Spring.

Senator Goedde understood that H1N1 dosages had been allocated based on population, asking if that were true in Idaho. **Dr. Hahn** answered yes. Although the federal government took some to vaccinate members of Congress and the military and sent some directly to Indian tribes and community health services, the rest was distributed to the states based on population.

The next presenter was **Richard Armstrong**, Director, Department of Health and Welfare (DHW) who spoke on the Medicaid shortfall. His presentation is available in LSO. Director Armstrong first gave an overview of the entire DHW budget and then addressed the 2011 Medicaid budget. **Director Armstrong** said that 84 percent of the Health and Welfare budget flows to private care providers in Idaho. Because DHW is predominantly privatized on a fee-for-service basis, its employees are engaged in such activities as eligibility determination, prior authorization, assessment, licensing and quality control. **Director Armstrong** showed a pie chart for 2010 original appropriation for the Division of Medicaid, a claims-paying system, pointing out that personnel represents only 1% of the budget, with 3% going to operating expenses and 96% going for trustees and benefits.

Director Armstrong said that in order to understand Medicaid, one needed to know about the Federal Medical Assistance Percentage (FMAP) history. In 2007 the federal government was paying 69.91% of all Medicaid bills; in 2009, he said the ARRA stimulus package (American Recovery & Reinvestment Act of 2009) increased the FMAP rate, with tiering based on the unemployment rate, moving Idaho up to roughly an 80% federal match. The federal requirement is that stimulus money be spent in order to stimulate the economy. However, he emphasized that under the present law, the FMAP amount drops to the 68.85% in January, 2011. **Director Armstrong** summarized that the temporary stimulus relief does not change everything going on today in health care. He said that in FY 2009, $21.9 million in case load growth reduced the actual $74.2 million in stimulus money to a net $52.3 million. In FY 2010, this $52.3 million base is being augmented by $112.1 million in additional stimulus funds with a reduction of $38.9 million due to caseload growth, netting a base of $125.5 million. Under these circumstances, a shortfall of $12 million is projected for FY 2010.

Director Armstrong said that DHW has made $75 million in changes, but cannot get changes

approved by CMC fast enough. The number of cases continue to increase. In addition, the private service providers are savvy billers who are able to seek additional payment even though the payment rate has not gone up. Further, the federal government has mandated some rate increases. He predicted that in FY 2011 the shortfall will amount to $130 million. A $130 million shortfall in general funds would result in a required cost savings of approximately $500 million due to the loss of matching federal funds, or about 31% of the Medicaid program.

Director Armstrong next showed a summary report on Medicaid Service Cost Drivers by category for FY 2003 through FY 2010, and a Division of Medicaid status report as of October, 2009, including changes under development to make up the differences in costs. The best area to control costs might be in the area of pharmaceuticals. He believes some changes might be rather bad health policy, but there is no choice since the budget must be balanced. He warned that these changes will be received very unfavorably and predicted legal challenges.

Senator LeFavour noted that Idaho already has stringent Medicaid eligibility requirements and inquired about what "wiggle room" is available under the federal law for Idaho to remain in compliance, post-ARRA. **Director Armstrong** said that federal statutes require certain core services, but there are a host of services driven by state statute. For example, there is no federal law that says Idaho has to deliver pharmacy benefits, even though not doing so would be a tragedy and would result in a huge spike in hospital care. Services required by state statute law may be eliminated or reduced, but there may be dire consequences for doing so. **Senator LeFavour** said that cuts might not be economically prudent and result in unintended consequences, suggesting that the increase in applications for the CAT Program is related to more stringent eligibility guidelines for Medicaid. **Director Armstrong** concurred that program cuts have consequences, some more long-term than short-term, such as in the area of dental services. He said that basic health and safety is the charge of the Idaho Constitution, but circumstances may require the Department to redefine what basic health and safety is. The Department will make the best choices it can make, given the circumstances, recognizing that his job is finding solutions.

Representative Rusche asked what impact the removal of $500 million in Medicaid expenditures might have on the economy, including job loss, increased premiums, cost shift to commercial payers and increased costs to indigent funds. **Director Armstrong** said that the Department has been moving so fast to come up with lists of proposed changes, there has been no time whatsoever to explore economic impact. **Representative Rusche** said in past years, hospitals have contributed to the federal match because it was in there best interest to do so and asked if there is an opportunity to seek such contributions since an industry that is faced with losing $500 million in revenue might be willing to come up with some of that in order to maintain their revenues. **Director Armstrong** said conversations have taken place and some hospitals have run the numbers. Some hospitals have indicated a willingness to take temporary reductions by returning interim payments. He has found cooperation among providers because they know we are all in this together and collaboration is imperative.

Senator Cameron pointed out that the projection based on the reduction in the FMAP matching rate and the increase in demand on services does not take into account any federal health care

reform legislation requiring states to expand Medicaid eligibility, asking if the problem might be even larger than portrayed currently. **Director Armstrong** agreed that this may be true, but noted that the proposed increase in Medicaid eligibility is not projected to occur until 2013 or 2014; however, last week the Department heard that the House might be considering some Medicaid changes going into effect in 2011 and 2012. Such changes would dramatically affect the Department's decisions. He noted that there is nothing going on at the national level to reduce costs or exposure eligibility to benefits, which makes this problem even more complex.

Senator LeFavour referred to the $500 million Medicaid shortfall and potential inability to make cuts to cover that amount. Fundamentally, she believes that we are trying to make the most vulnerable people pay to balance the budget and suggested that perhaps people who have a job could do more to balance the budget.

Director Armstrong said that he did have some good news - the Department's IBUS system went up this weekend and is operating at a 95% confidence level. This has been a wonderful conversion and the results are very pleasing.

The task force recessed for lunch at 12:05 until 1:30 p.m.

Dr. Gary Krouth, System Vice President and Chief Medical Reform Officer, St. Luke's Health System, presented a PowerPoint presentation titled "Health Care Reform - Selected Observations" which is on the LSO legislative website at:

www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare1104_krouth_presentation.pdf

Dr. Krouth clarified that he was not representing St. Lukes in making his presentation to the task force. **Dr. Krouth** said he represented thirty years in health care and wanted to highlight what has been overlooked in current health care reform discussions. He acknowledged that the debate about health care delivery reform is really about the cost of care, not on health care expenditures. His presentation covered what he felt are wasted health care dollars, an example of which are risky behaviors such as obesity. He characterized health insurance as not really insurance but as health care financial planning. **Dr. Krouth** said it seemed to him there are only two rational approaches:

- High deductible health insurance plans with an HSA; or
- A public health care delivery system paid for by increased taxes and which would require rationing of access, services, and supplies.

According to **Dr. Krouth**, we need to put health care choices back into the hands of the consumer.

Julie Taylor, Director, Governmental Affairs, Blue Cross of Idaho, shared with the task force what the impact would be on the insurance market with proposed federal health care reform. **Ms. Taylor** said a consulting firm did an analysis of the proposed federal, which is contained in handouts titled "Oliver Wyman - Additional Background and Frequently Asked Questions on the Oliver Wyman Report on the Impact of Health Insurance Reforms" and "Oliver Wyman -

Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability - October 14, 2009." She also handed out a letter from the National Association of Insurance Commissioners (NAIC) dated October 27, 2009 to The Honorable Harry Reid, Majority Leader, US Senate, Washington, D.C. and all of these handouts are available in LSO.

Dave Hutchins, Vice President, Actuarial Services and Underwriting, Blue Cross of Idaho, presented a PowerPoint on "Impact of Federal Reform on the Idaho Individual Market," which is available at LSO and on its website at:

www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare1104_hutchins_presentation.pdf.

Mr. Hutchins' presentation, based on the proposed Senate bill, compared the pre-reform, October 2009 monthly premium rates on a $5,000 deductible PPO Plan for a health, age 26 males at $83.60 and females at $112.62, with a post-reform premium rate for both age 26 males and females at $201.90. (The proposed Senate bill would remove the gender rating.) The annual post-reform cost of insurance for this age group would be $2,422.80, compared to the penalty for not buying insurance, which is $0 in 2013 increasing to $750 in 2017 in the Senate bill. Blue Cross of Idaho currently offers 28 plan designs ranging in price from $38.26 to $176.57 monthly for a 26-year-old healthy male as compared to post-reform benefit options and premium rates that range from $202 to $292 monthly. **Mr. Hutchins** said these numbers assume the young and healthy will continue to buy insurance because of government subsidies and mandated coverage. Under these provisions, many of the young and healthy will find it much cheaper to pay the penalty and not buy insurance until they have a health care emergency. The consequences for the Idaho individual market, based on the Oliver Wyman analysis that takes into account the subsidies and mandates features of the Senate Finance Committee bill, is that the cost of insurance will go up an additional 47% by 2017. For a 26-year-old male, the cost of insurance will increase 255%.

Senator LeFavour commented that **Mr. Hutchins** information did not take into consideration that increasing the numbers of insured will reduce unpaid hospital and emergency care, a major cost driver. **Mr. Hutchins** said he did not know that the number of insured would be increased, but perhaps there might be a shift of people into Medicaid.

Representative Rusche asked if **Mr. Hutchins** was confident that uninsured have a greater degree of burden, recalling a study showing that 80% of uninsured in Idaho were young working families. **Mr. Hutchins** said he was relying on his Oliver Wyman research.

Senator Cameron asked how Idaho compares to other states in overall cost considering that states like New York have implemented mandates that are included in the proposed Senate bill. **Mr. Hutchins** affirmed that Idaho has the greatest variance allowed, so Idaho will get the full 47% increase and states like New York will not. First projections show that the level of uninsured in Idaho is likely to go down. **Ms. Taylor** referred to a Commonwealth Fund study showing that Idaho currently has the lowest rates for small group insurance.

Senator Cameron followed up on **Senator LeFavour**'s question saying one problem in the

Senate proposal is that since a young 26-year-old could buy coverage the day of an accident or diagnosis of an illness, why would insurance be purchased in advance, especially since there is no incentive to do so under the proposed legislation. **Mr. Hutchins** answered that under the proposal, a rational person would not buy insurance.

Senator Cameron asked about the preliminary Congressional Budget Office Report dated October 7, 2009, pointing out that the insurance subsidy is tied to the deficit and would reduce to zero as the deficit increases. Senator Cameron also expressed concern that Congress is essentially giving away its authority to commission for committees that can regulate. **Mr. Hutchins** said that could drive insurance costs through the roof. **Representative Wood** said he had read an executive summary and that was exactly what he had read, believing that Congress truly is giving away its authority. **Representative Marriott** said he was disturbed that committees or persons in charge have authority to enforce severe penalties without due process.

Senator LeFavour said she understood that those people who are young and healthy may not be motivated to buy insurance, but the people who are driving health care costs are those with health problems who cannot afford health insurance. The proposed federal legislation will make insurance more affordable for those people. To assume there won't finally be more coverage is in error. **Senator Cameron** said he could not disagree with **Senator LeFavour** more. His experience is that generally uninsured individuals are healthy. If a penalty amounts to $750, and monthly coverage costs up to $250 monthly, healthy people will not buy coverage since they can get coverage when needed with no incentives to buy ahead of time, except the desire to be a good citizen. **Senator Cameron** added that High Risk Pool premiums are not that expensive compared to the traditional product. **Ms. Julie Taylor** directed the task force to paragraph 5 of the NAIC letter to The Honorable Harry Reid dated October 27, 2009, that states: "We do not believe the committee-passed mandates and subsidy structures will be effective enough and the resulting adverse selection could undermine the overall reform effort."

Senator Goedde referred to a chart handout showing that about 25% of uninsured earn over $70,000 annually, believing that cost is not an issue for those uninsured people. This chart is available at LSO.

Next on the agenda was a panel discussion on the federal health care reform. Panel members were asked to address three questions:

1. Should Idaho opt in or out (pros and cons);

2. Should Idaho amend its Constitution as proposed in Arizona to limit a public option (pros and cons);

3. What could be or should be done for health care reform in Idaho?

Susie Pouliot, Idaho Medical Association (IMA), provided the task force members with a handout, "Idaho Medical Association Policy on Health Care Reform," dated July 26, 2009, (available at LSO). Ms. Pouliot said that proposed health care reform changes every day as it moves through the process, adding that it was very difficult to pin down pros and cons of issues that are not final. She said that Idaho doctors are on both sides of the issue on whether there

should be a public option insurance plan, but a majority of the IMA has come out against that prospect. The IMA strongly supports universal coverage and access to health care but not necessarily a single-payer system. **Ms. Pouliot** commented that federal law might preempt the state Constitution, so didn't know whether an amendment to opt-out of the federal reform would be worthwhile for Idaho to consider. She said the IMA supports health care reform that:

1. Improves the health care system through expansion of health care access;
2. Improves quality of care;
3. Reforms government programs;
4. Reduces cost;
5. Increases focus on wellness/prevention;
6. Reforms payment and delivery systems;
7. Increases patient access by reducing physician workforce shortages.

If adequate health care reform occurred, **Ms. Pouliot** stated that Idaho would not have an adequate physician workforce to take care of all patients. Idaho ranks 50th among states for doctor-to-patient ratio, and the IMA backs increased medical education and training and other tools to get more physicians practicing in Idaho. She also wondered if current programs, such as the SCHIP program, are being adequately marketed to reach all eligibles.

Representative Marriott asked about the IMA suggestion on reforming payment and delivery system by providing antitrust relief to improve quality and care coordination. **Ms. Pouliot** said that suggestion sought to remove antitrust regulations that prevent partnerships between hospitals and clinics.

Senator Cameron asked about the reimbursement level of Medicaid and Medicare, adding that if Congress provided payment for the actual cost of medical services under these programs, premiums could be reduced by about $1600 for a family of four. **Ms. Pouliot** stated that this was addressed in the IMA policy statement on reforming government programs by ensuring adequate payment.

Senator Cameron said one suggestion for reducing medical costs would be to provide additional competition between physicians by increasing the number of physicians practicing in Idaho and asked whether the IMA has a position on that. **Ms. Pouliot** said that increasing access to medical education and graduate medical education is one of the highest IMA priorities. The IMA supports expanding WAAMI seats, graduate education and residency programs, as well as moving forward on formation of a four-year, Idaho-based medical education program. The IMA has not taken a position on how that may be achieved. The IMA is also looking to create a pool of funds that would provide incentives for physician recruitment tools, especially with the excellent tort liability environment in Idaho. In Wyoming, physicians who agree to practice in under-served areas are paid $30,000 annually for three years to help offset medical education debt. In return, the physician must agree to see Medicaid and Medicare patients as well as SCHIP patients.

Senator Goedde asked if there is a correlation between the low number of physicians in Idaho and cost of health care, or if it is an access issue. **Ms. Pouliot** responded that she didn't know; when patients do not have access to care, sometimes problems end up requiring emergency care, which is not cost efficient. **Senator Goedde** asked **Ms. Pouliot** about providing antitrust relief and if this had anything to do with self-referral of physicians to physician-owned facilities. **Ms. Pouliot** said it does not, but instead focuses on breaking down antitrust barriers to forming partnerships between facilities and communities. **Representative Rusche** said that perhaps an actuary could better answer **Senator Goedde's** question. **David Hutchins** opined that he does not believe that the number of physicians in Idaho is driving health care costs.

Joy Wilson, National Conference of State Legislatures, updated the task force on proposed federal health care reform legislation via conference call. **Ms. Wilson's** PowerPoint presentation is available at LSO and at:
www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare1104_wilson_presentation.pdf.

Ms. Wilson began by saying her planned presentation had changed considerably since preparing it 24 hours before, so she shared more current information. With regard to the Senate Bills, S. 1679 and S. 1796, she said that Senator Harry Reid held a press conference supporting the inclusion of the public option with a state opt-out. However; to date no language has been released. **Ms. Wilson** said that Majority Leader Reid did not have the necessary 60 votes to break a filibuster in support of a public option, a critical issue for the Senate. There are several public option proposals floating around, and **Ms. Wilson**'s prediction was that the Senate would not complete its deliberations by Thanksgiving, which would push the Senate into December and make it questionable whether a consensus could be reached between the House and the Senate before Christmas. Some are saying the new deadline date is the State of the Union Address in January. She said negotiation and posturing is going on and there are no "done deals" with regard to health reform.

Ms. Wilson said that Republicans have a number of different proposals, one they call universal access, a combination of risk pools and reinsurance to expand coverage to more people through insurance in lieu of limiting insurer's ability to impose a pre-existing condition exclusion. There is also a proposal to allow persons to purchase insurance outside the state in which they reside. Other provisions discussed include: limiting medical liability; prohibiting insurers from imposing annual or lifetime caps; prohibiting insurers form rescinding coverage absent a showing that beneficiary had provided fraudulent information; providing incentive payments to states that reduce number of uninsured and the cost of premiums in the state; and allowing individuals to use health savings accounts to pay premiums for long-term care insurance. So far, the Republican proposals have not had a Congressional Budget Office cost estimate done. **Ms. Wilson** could not find the offset for any costs associated with that market oriented proposal and noted that, but it imposes no mandates and no Medicaid expansion.

Ms. Wilson addressed the changes made in House bill, H.R. 3269, since she last spoke to the task force: the Medicaid floor was raised on minimum eligibility from 133% of poverty to 150% of poverty; the enhanced federal match for new eligibles (100% federal match for first two years) was increased from 90% to 91% for fiscal year 2015 and thereafter; the American Recovery and Reinvestment Act (ARRA) Medicaid enhancement has been extended an additional six months

to June 30, 2011, in order to cover an entire state fiscal year; a large piece of legislation very important to Indian tribes has been added, which is "The Indian Health Care Improvement Act"; and supplemental payments were added to Medicaid nursing facilities that have disproportional Medicaid beneficiaries. New amendments are being presented, and **Ms. Wilson** said the NCSL website would be updated daily with changes.

Senator McGee asked what the chances are of health reform passing and **Ms. Wilson** said she was predicting a less than 50/50 chance, depending on if the Senate can get a bill. The Senate Democrats seem to be split, and the Speaker does not have the votes locked up in the House.

Representative Wood referred to the Medicaid reimbursement rate for the new eligibles being increased from 90% to 91% in 2015, and asked what the House bill said about existing eligible. **Ms. Wilson** answered that Idaho has not expanded Medicaid as much as other states and thus would get a fair amount of enhanced match, since Medicaid eligibility in Idaho is currently below 150% of poverty.

Representative Wood asked whether the extension of the ARRA Medicaid enhanced rates to June 30, 2011, which is in the current House bill, would be included in the Senate bill, a matter that is huge for Idaho. **Ms. Wilson** said that if the Senate failed to extend ARRA, then states would be allowed to lift the pre-health reform maintenance of effort requirement. **Representative Wood** asked if **Ms. Wilson** had heard there is a consensus on Senate side about that and she answered that she did not have that information. She said that there may be a consensus to do it, but maybe not in the health reform bill itself; there is possibility of doing an ARRA extension in a supplemental, which would not require an offset. **Ms. Wilson** said the doctor reimbursement rate issue is a real problem and has been taken out of the House bill and is floating as separate legislation, without a consensus. Physician groups are concerned about how this is being handled, and the Senate has not removed this in its bill, so it may end up back in conference, if the Senate and House can get there. The complication is that if health care reform moves into January, the physician payment reduction will become effective January 1.

Representative Rusche asked whether there is any talk of a drop-back position, if health reform fails to pass. **Ms. Wilson** said someone may blink before the reform effort fails. There are a number of proposals being floated but none have a majority vote, adding that there is a lot of behind-the-scenes activity. Given that next year is an election year, the chance of reform passing next year is minimal.

Senator Cameron asked whether the Governor elections that occurred the previous day might affect the health care reform debate **Ms. Wilson** answered that moderate Democrats are polling on this issue and that the pundits are divided on whether these elections were significant, given that candidates in New Jersey and Virginia had their own problems. **Ms. Wilson** said that many people are focused more on the economy than health care right now, which could affect the legislation more than the elections. **Representative Collins** thanked **Ms. Wilson** for her current updates to the task force.

The meeting continued with the panel discussion. **Steve Millard**, Idaho Hospital Association, stated that hospitals are for reform, if done right. **Mr. Millard** pointed out that Idaho has

problems with access to medical care, and that we do need real health reform. He said that the Idaho Hospital Association is against a government-run public option. The American Hospital Association has made a deal with the Chairman of the Senate Finance Committee to get more insured people, giving up $155 billion over ten years in Medicare and Medicaid reimbursements. **Mr. Millard** said that amendments to the Constitution are not easy. He said that last year, Idaho hospitals were under-reimbursed by Medicaid, Medicare and the CAT Fund in the amount $213 million. Perhaps the solution would be for government payers to pay what private insurance pays to reduce insurance premiums for everybody. **Mr. Millard** said payment reform needs to happen as well as better agreement on hospital readmissions.

Steve Thomas, Idaho Association of Health Plans, spoke next, providing the task force with a handout, "Transforming Idaho's Health Care System," which is available at LSO. **Mr. Thomas** said that the members he represents do not care for the public option, adding that it is too soon to judge possible health care reform since it is changing so fast, and the devil is in the details. With regard to amending the Constitution, he wondered if a state Constitutional provision would trump federal statute, assuming a clear conflict. Constitutional Amendments in Idaho must go to the Attorney General, and that opinion would be welcomed before his members expressed an opinion. **Mr. Thomas** said that the insurance industry is willing to give up price discrimination but needs a viable mandate to require people to purchase insurance. He said that Idaho has low-cost premiums so Idaho is doing some things right; however, Idaho needs to reduce unnecessary waste, maintain affordable options and improve quality of care.

David Irwin, Communications Director, AARP, Idaho, said that the American Association of Retired Persons has 185,00 members in Idaho and 40 million nationally. Members aged 65 and older spend an average of 30% of income on health care expenses, and members still in the workforce struggle with skyrocketing health insurance premiums, which are expected to increase by 40% in the next four years and double in the next seven. **Mr. Irwin** said that current draft legislation would allow states to opt-in or opt-out of public option, the issue being extremely controversial. He said public option could allow Idaho's growing ranks of uninsured and those struggling with soaring costs a viable and affordable option. Opting out could have unintended consequences; this could reduce or cut federal relief for our state's increasing number of uninsured, further eroding critical services. Opting out could also vastly reduce Idaho's bargaining power for better health care prices. **Mr. Irwin** said that AARP has not yet endorsed the pending federal health care legislation, but AARP does support a plan that closes the Medicare Part D coverage gap, known as the "doughnut hole." **Mr. Irwin** said that with regard to Idaho amending the Constitution as proposed in Arizona, Idaho's requirement that college and university students purchase health insurance would be in violation of such an amendment. **Mr. Irwin** said that AARP commends Idaho for its focus on home and community-based services, allowing people to stay in their homes longer, age with dignity and being more cost effective than institutional care, which should be continued. AARP believes that Idaho can tackle high drug costs by helping consumers find the best drug at the best price by making prices available on-line to consumers as well as generic information for comparisons. AARP thinks that hospital discharge planning needs to be addressed to avoid costly hospital readmissions under Medicare. Establishing greater transparency into soaring health insurance premiums can ensure profits don't come before people and patients. AARP encourages taking politics out of health care debate and

putting patients at the heart of the debate; fix what's broken and preserve what's right.

Alex LaBeau, President, Idaho Association of Commerce & Industry (IACI), believes Congress should be encouraged to deal with health reform, deal with defensive medicine issues, transparency issues giving consumers more information about providers, focusing on general practitioners being managers of the health care system and corresponding reimbursements for individuals. **Mr. LaBeau** said that IACI thinks that with most health reform proposals, essentially 85% of Americans would be punished for the benefit of 15% of Americans. One reform that Congress should look at is simply improving reimbursement levels to private providers for Medicare and Medicaid. **Mr. LaBeau** said that IACI is not prepared to say that Idaho should opt-out of the public option; reform is needed, and the state and Idaho businesses should engage in the national debate.

Tom Shores, Idaho Association of Health Underwriters, said that with regard to the public option, costs of plans proposed could end up making coverage more costly. Addressing the issue of people who want health care but cannot afford it would make more sense. **Scott Leavitt**, Idaho Association of Health Underwriters, said that since final details in health reform legislation are being worked out, but cautioned that opting out would require the states to do something better. With regard to Idaho amending its Constitution as proposed in Arizona, he said his Association is opposed to a public plan option. **Mr. Leavitt** believes that flexibility should be allowed in creating an insurance exchange, and suggested a combination of the Oregon low-income subsidy program and what Utah has done with their exchange where subsidies are available for individuals to purchase private coverage on a sliding scale based on income. He suggested that a virtual exchange may work. **Mr. Leavitt** said Oklahoma has a three-share program with premiums shared by employers, the state and the employee, which is very successful due to promotion by brokers. Price transparency, wellness provisions, health-related excise "sin" taxes in financing health reform could help deliver revenue and simultaneously discourage unhealthy lifestyles. He also believes that insurance agents should be used to help promote private health insurance options, whether through an exchange, current products or to assist with SCHIP enrollment.

Senator LeFavour asked **Mr. Leavitt** if he supports public tax dollar subsidies to private insurance companies, a perpetuation of the current broken system, as the solution. **Mr. Leavitt** said the system should be fixed, encouraging healthy lifestyles and subsidies to take care of people with private insurance, since private insurance is the best financial vehicle.

Representative Rusche asked about state-subsidized free insurance for small and individual product and **Mr. Leavitt** agreed to look at all 50 states, adding that some phased-in subsidy programs work well.

Denise Chuckovich, Executive Director, Idaho Primary Care Association (IPCA), began by stating that 50% of the people seen at the 12 community health centers in Idaho are uninsured. IPCA believes health reform should strive to achieve universal coverage, available and affordable to everyone; coverage should be comprehensive and should emphasize prevention and primary care; reform should insure everyone has access to a medical home, where they can receive high quality, cost effective care. **Ms. Chuckovich** said with regard to opting-in or

opting-out, it is too early to make a recommendation. She urged caution and thorough study prior to any decision, adding that the Senate bill will allow states until 2014 to decide.

A Constitutional amendment to opt-out raises concerns, seeming ill-advised. **Ms. Chuckovich** offered solutions for health care reform in Idaho in areas of access, including a state policy framework that supports universal coverage and increased numbers of medical residency seats for Idaho. Other solutions are cost and quality issues including state policy frameworks for supporting:

- further development of the patient centered medical home model;
- provider reimbursement for medical home;
- the continuation of Idaho health data exchange;
- increased provider implementation; and
- increased focus on personal responsibility for healthy lifestyles.

Ms. Chuckovich said that there is much that can be done at the state level to develop a policy framework that invests in health care and reduces costs.

Heidi Low, American Cancer Society, said that good access to quality, affordable health care for all Americans is important. She said the American Cancer Society does not have an opinion at the federal level or at the state level, but are looking at all options based on merit. Prevention, early detection, diagnosis and providing quality care for cancer patients in treatment is critical. With regard to Idaho opting in or out, further ramifications would need to be examined. Amending the Constitution would be difficult and federal law would trump the state Constitution. Quality of Idaho's health care system will affect success of the fight against cancer and all Idahoans should be provided access to high-quality health care which would significantly reduce cancer incidents, mortality, and quality of life for cancer patients.

Suzanne Budge, National Federation of Independent Businesses, shared research with the task force. She handed out a packet titled "What Small Business Wants from Healthcare Reform," which is available in LSO. Cost of health insurance has been the number one problem facing small businesses for more than 20 years. Health care reform for small businesses must address the 3 C's: cost, choice and competition. **Ms. Budge** emphasized that small business owners want a uniform benefit package that can be portable from job-to-job and state-to-state which big business has today. She said an employer mandate fails to address the real problem facing small business owners and their employees, which is the cost of insurance. A truly competitive and reformed private insurance market can best provide small business owners and their employees with greater affordability and sustainable choice of plans. **Ms. Budge** said that with regard to opting in or out, the state will never opt out of financial requirements. From a tax standpoint, small businesses are extremely concerned now and for the future; small businesses are almost paralyzed with fear due to extraordinary uncertainty.

Cameron Arial, Zions Bank and Idaho Chambers of Commerce, said that Zions Bank was the largest small business administration lender in Idaho for the last eight years, and for the last 12 years the largest small business lender in Utah. He expressed concern about health care reform

and said that with regard to opting in or out, he had no opinion since it is unknown exactly what that means at this time. A number of Chambers of Commerce throughout Idaho have opposed public option and other provisions. A Constitutional amendment is not supported at this time. Main street businesses in Idaho, in the current recession scenario, would be crippled with any increase in taxation or cost to do business. The future of this country, he believes, is in risk-taking, innovative small businesses. He urged this task force and the Legislature to influence the debate in support of small businesses. He said that recovery and expansion of an economy is where jobs are created, but it is during a recession where industry, innovation and efficiency are created. He expressed hope for visionary approaches, recognizing opportunities to make changes to improve health care in our country.

Representative Collins announced the next meeting would be held on November 30, 2009. **Senator Cameron** urged caution with regard to future meetings after the November 30th date, due to the move back into the Capitol and requirements on staff. If there is a need for another meeting prior to session, he said that leadership could be approached for permission to do so. **Senator Cameron** invited anyone interested in introducing draft legislation to contact the co-chairs as soon as possible for consideration prior to the next meeting on November 30th.

Representative Collins adjourned the meeting at 4:05 p.m.