MINUTES

(Approved by the Task Force)

HEALTH CARE TASK FORCE

Boise, Idaho
November 30, 2009

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

Others attendees were: Senator Joyce Broadsword, District 2; former Representative Margaret Henbest, Idaho Alliance of Leaders in Nursing and Governor Otter's Behavioral Health Transformation Workgroup; Jeremy Pisca, Risch Pisca, PLLC, Saint Alphonsus Regional Medical Center and Pharmaceutical Research & Manufacturers Association (PhRMA); Jaime Newton, Idaho State School and Hospital (ISSH); Lyn Darrington, Regence BlueShield of Idaho and Business Psychology Associates; Suzanne Budge, SBS Associates; Susie Pouliot, Molly Steckel and Ken McClure, Idaho Medical Association (IMA); LaDonna Larson, Idaho Health Data Exchange (IHDE); Trish McDaid-O'Neill, AstraZeneca; Angela Torres, Health Management Systems (HMS); Skip Oppenheimer, Governor Otter's Behavioral Health Transformation Workgroup; David Lehman; Thomas R. Young, M.D., Children's Home Society; Dallas Clinger, Harms Memorial Hospital; Matt Hunter, Greater Pocatello Chamber of Commerce; Kurt Stembridge, GlaxoSmithKline; Steve Tobiason, Woody Richards, Doug Dammrose, M.D. and Julie Taylor, Blue Cross of Idaho; Benjamin Davenport, Risch Pisca, PLLC; Kathie Garrett, Partners in Crisis; Skip Smyser and Martin Bilbao, Connolly & Smyser, Chartered; Joie McGarvin, America's Health Insurance Plans; Larry Benton and Kris Ellis, Benton, Ellis & Associates; Dick Schultz, Cynthia York, Jane Smith, Rebecca Coyle, Traci Berreth and Chris Hahn, M.D., Department of Health and Welfare (DHW); Amy Holly, Business Psychology Associates; Jon Smith, The Hospital Cooperative; McKinsey Miller, Gallatin PA; Elizabeth Criner, Veritas Advisors, LLP; Corey Surber, St. Alphonsus; Shaun Menchaca, Portneuf Health Care Foundation, Pocatello; Paul Nielsen and Gene Tosaya, MedImmune; Heidi Low, American Cancer Society, Cancer Action Network; Nick Genna, Treasure Valley Hospital; Ron Rock, Northwest Speciality Hospital; Raulo Frear, Pharm.D., Regence BlueShield of Idaho; Michelle Britton, Division Administrator, Family and Community Services, Idaho State School and Hospital (ISSH); and Joy Wilson, National Conference of State Legislatures (by conference call).

Co-chair Senator Dean Cameron called the meeting to order at 10:29 a.m. **Representative Rusche moved that the Minutes from November 5, 2009 be approved, seconded by Senator McGee, and approval was by a unanimous voice vote.**

Senator Joe Stegner reported that the Mental Health Subcommittee had not met since the task force's previous meeting. However, Governor Otter's Behavioral Health Transformation Workgroup has been meeting and its chairman, **Skip Oppenheime**r, is scheduled to present to this task force. **Former Representative Margaret Henbest** and Department of Health and Welfare Director **Richard Armstrong** are also members of that workgroup.

Mr. Skip Oppenheimer, Chairman of Governor Otter's Behavioral Health Transformation Workgroup, informed that the workgroup will meet next on December 2, 2009, and he gave a brief overview, vision and goals in a PowerPoint presentation which is posted on the LSO website at:
http://www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare1130_oppenheimer_presentation.pdf

Mr. Oppenheimer said there have been many efforts over the years to deal with mental health, but little has happened; he believes that the present workgroup has a significant chance of success to improve the mental health delivery system in Idaho due to the participation of its members. The workgroup's vision is: "Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable, and focused on recovery." The workgroup's goals are:

- Increase the availability of, and access to, quality services;
- Establish a coordinated, efficient state and community infrastructure throughout the entire mental health and substance abuse system with clear responsibilities and leadership authority and action;
- Create a comprehensive, viable regional or local community delivery system;
- Make efficient use of existing and future resources;
- Increase accountability for services and funding; and
- Provide authentic stakeholder participation in the development, implementation and evaluation of the system.

Phase 1 is under discussion and development and includes: a phased-in approach, which is methodical, measurable and manageable; and development that is informed by data and directed at vision and goals. The workgroup's next steps will be to articulate and agree on Phase 1; generate status report to Governor; and conduct public involvement.

Mr. Oppenheimer introduced former **Representative Margaret Henbest,** a member of the workgroup. **Representative Henbest** stated that this is a tedious, arduous process to discern what Idahoans and policymakers want and believes that the end result will be very unique to Idaho. There is much work ahead and the workgroup is looking forward to reporting to the Governor at the end of this December and aggressively reaching out to regions and stakeholders for a response to what has been formulated.

Senator LeFavour asked where the Regional Mental Health Boards fit in to the regional plan or whether the workgroup envisions some other coordination effort for these Boards. **Director Armstrong** answered that it is absolutely the plan to make use of existing structures rather than create new structures. There may be some consolidation of the Regional Advisory Committees on Substance Abuse and Regional Mental Health Boards into a single organization. **Director Armstrong** noted that the Boards offer tremendous opportunity for local collaboration. **Senator LeFavour** commented that the Boards are not always staffed and vary in effectiveness from one to another and asked whether there is a vision for giving the Boards resources. **Director Armstrong** answered that first the Boards need to be clearly defined, understanding that if communities are going to be asked to deliver services, a local business entity must be developed with staff.

Representative Block asked if **Director Armstrong** sees a need for legislation and, if so, when. **Mr. Oppenheimer** said that the workgroup needs more time to design ideas and to get feedback from stakeholders around the state. The time line the workgroup is now shooting for is July or August of 2010, and any legislation will come out of the final design. The picture will become clearer over the next several months, especially with public input. **Former Representative Henbest** commented that one challenge for the workgroup is to develop a vision of a behavioral health system that combines advisory boards that have siloed mental health delivery. Flushing out what that regional system will look like, making decisions, running contracts and providing services will clearly have legislative ramifications.

Senator Stegner stated that the goal of having the state be a guarantor of services might disturb or shock some people. The report prepared by the Western Interstate Commission on Higher Education (WICHE) recommended that the state be the guarantor of these services rather than the provider or deliverer of these services. **Senator Stegner** explained that there is already statutory language that suggests that the state is already in the position of being a guarantor, so this goal is not a significant change in policy but an interpretation. The role and obligation of the state would not be significantly changed from what it already is. Additionally, that goal should not be taken to suggest that counties will automatically be relieved of financial participation. The counties strongly understand their role in this combined effort and are not trying to eliminate or transfer their financial responsibilities. This is to be a team effort. **Senator Stegner** emphasized that the whole concept of a more regional, local system is designed to allow those regions a

certain amount of autonomy in designing their own delivery system, recognizing their own available assets and priorities. Minimum standards must be maintained and that will be a challenge, but a regional delivery system will have great potential for significantly improving that system.

Mr. Oppenheimer responded that a model for a decentralized delivery system has a huge amount of potential both in quality of service delivery and local regions and communities taking ownership with better efficiencies. Time is now being spent on designing the system and planning on how to phase it in. All stakeholders are trying to stay connected through this process.

Representative Gary Collins gave a brief update on the Immunization Subcommittee. The minutes of the November 30, 2009, subcommittee meeting are available at the LSO website at: http://www.legislature.idaho.gov/sessioninfo/2009/interim/immunizations1130min.pdf

Representative Collins said the goal of the subcommittee is to come up with alternative funding for the state immunization program before January 30, 2010, the date that the current emergency funding will end. The subcommittee is advancing toward the goals of continuing the immunization program and making it better. The subcommittee still does not have answers but is moving towards conclusions. **Senator Cameron** added that future meetings of the subcommittee will be necessary, especially since health care reform nationally may affect decisions in Idaho.

The next presenter was **Mr. Brad Huerta**, Director of Public Affairs and Marketing, Portneuf Medical Center (PMC), Pocatello, whose PowerPoint presentation entitled "Eastern Idaho EMR - An Overview of Past and Future Regional Projects: is on the LSO website at:http://www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare1130_huerta_presentation.pdf

Mr. Huerta shared what is going on in eastern Idaho in partnership with critical access hospitals regarding electronic medical records. He introduced **Shaun Menchaca**, President and CEO of Portneuf Health Care Foundation. **Mr. Menchaca** said that the focus of the Portneuf Medical Center (PMC) is to provide education on technology activities in eastern Idaho; to foster discussion in the area of electronic record development for Idaho; and to provide support for cost-effective delivery of patient care for Idahoans. **Mr. Menchaca** said that PMC and its partners in The Hospital Cooperative have a long history of matching federal dollars with private dollars to invest in health care needs in eastern Idaho. There are currently eleven hospitals and two clinics participating in the telemedicine program, mostly with regard to mental health consultations. Since 2002, PMC has participated in multiple regional projects that have benefitted all of eastern Idaho using public dollars.

Mr. Huerta said that The Hospital Cooperative is a network of about 14 hospitals, 12 of which are critical access hospitals. **Mr. Huerta** introduced **Jon Smith**, Executive Director, The Hospital Cooperative, Pocatello, Idaho. **Mr. Smith** said that The Hospital Cooperative is an umbrella organization created for the health care facilities in eastern Idaho to leverage both resources and talent to provide for the continued success of rural, critical access hospitals. This network of 14 hospitals in southeastern Idaho and western Wyoming was established in 1994 to provide benefits to members through shared resources, services and information. The latest effort, electronic records, has focused on creating better access for care; interest in connecting community entities; focus on becoming "meaningful users"; interconnectivity of all systems; and return on investment for partner hospitals and clinics.

Mr. Huerta said that the electronic medical records system that has been deployed in eastern Idaho is fully functional. There are over 100 providers already using it, with additional providers being added to the system. This electronic medical records system is endorsed by the Certification Commission for Healthcare (CCHIT).

Mr. Huerta introduced **Mr. Dallas Clinger**, CEO, Harms Memorial Hospital, American Falls, Idaho, to speak about the struggles for critical access hospitals and specifically how they will be impacted by electronic health care records. **Mr. Clinger** said that he fully supports the focus of the Idaho Health Data Exchange (IHDE) and the concept of connectivity. He expressed concern about the cost of $30,000 per critical access hospital, $750 per provider and $250,000 for the PMC per year. He expressed concerns that the IHDE model is not sustainable; even if its services were initially provided free of charge to the critical access hospitals, they would not be able to pay for the ongoing cost. **Mr. Clinger** said that eastern Idaho already has an electronic medical records effort underway that enjoys broad support and buy-in from hospitals and providers. In its current form, the eastern Idaho electronic medical records system is one-third the cost of the IHDE program and can be deployed in 12-18 months as opposed to 3-5 years.

Mr. Huerta closed by recommending continued deployment of the eastern Idaho electronic medical records system at a cost of one-third that of the IHDE.

Senator Goedde asked why the eastern Idaho electronic medical records system is not embraced by the entire state. **Mr. Huerta** answered that it is because others did not know about this system and what is being done in eastern Idaho, believing it to be a matter of education. He believes this model is sustainable and cost-effective and could be rolled out significantly quicker than what hospitals and clinics have currently.

Representative Rusche asked if this was another model among many that happens to fit a market area. **Mr. Huerta** said that this is a model that works for eastern Idaho; what works for one region may not be as effective in other regions. This regional solution, however, is one that lends itself to tying in with a statewide solution. **Representative Rusche** commented that one

big player is missing, asking why. **Mr. Huerta** answered that Eastern Idaho Regional Medical Center has been invited to be part of this program, but it has chosen not to do so, and that another product had been chosen.

Representative Elaine Smith asked how many eastern Idaho hospitals support the IHDE. **Mr. Huerta** answered that last spring the IHDE met with all the representative hospitals and presented its cost structure and time line. None of the hospitals were in support of IHDE at that time and that position has not changed. One of the big reasons is cost; it is not a vote against electronic medical records, or one product against another. Long-term costs cannot be sustained, even if given free of charge for several years. **Senator Cameron** commented that this is an interesting dilemma.

Ms. LaDonna Larson, Executive Director, Idaho Health Data Exchange (IHDE), the next presenter, commented that **former Senator Compton** had previously asked the task force to support the IHDE's stimulus grant application that would help defray some costs for critical access hospitals. IHDE was told by the federal government that outpatient would be about $5.9 million, which is about one-third of what was originally asked for. **Ms. Larson** said IHDE's goal is and continues to be connecting Idaho to ensure good quality and coordination of care. The IHDE is partnering with eastern Idaho and is seeking funding through the grant application to connect it to the statewide health data exchange.

With regard to **Senator Goedde's** question about why all providers in the state are not connecting to IHDE, **Ms. Larson** agreed that cost is one of the issues. When the IHDE model was developed, the economy was very different; IHDE will be looking at what can be done with today's economy. IHDE needs to be a sustainable organization regardless whether any federal funding is available. Incentives have been made available through Medicare and Medicaid for adoption and meaningful use of electronic health records, so funding sources other than stimulus monies are available to critical access hospitals. Cost for adoption of electronic health records by ambulatory care physicians is also an issue; the Medicare incentive is up to $44,000 over a five-year period, and the Medicaid incentive is up to $55,000 over a five-year period. **Ms. Larson** encouraged not looking at just one pot of money to leverage all the funding that is available.

Senator Cameron asked about the time frame for notification of whether the IHDE grant application has been approved. **Ms. Larson** said IHDE should know by December 15, 2009.

Senator Cameron inquired about the other funding sources and whether available only for hospitals entering into the program. **Ms. Larson** said the Centers for Medicare and Medicaid (CMS) are in charge of incentives and review of each state's Medicaid program regarding meaningful use and that is underway. Part of demonstrating meaningful use is the active exchange of health information, which is to begin in 2011. Idaho's health data exchange is active with three connected hospitals and two connected labs. With regard to Eastern Idaho

Regional Medical Center, IHDE is looking at getting the connection implemented. If a hospital is ready, IHDE is ready.

Senator Cameron commented that this task force endorsed the IHDE grant application; the last thing he wants to see is two competing exchanges or networks, which would not be good for either the citizens or the provider network. The inference is that grant funds are to be used statewide, not just in one region. He expressed hope that funds are allocated appropriately and shared. He appreciates IHDE's willingness to do so.

Representative Wood observed that several hospitals are developing regional electronic medical record systems and asked whether the role of the IHDE will be to coordinate various systems already in existence or to supplant those systems with a competing model. **Ms. Larson** answered she did not see IHDE as a "competing model" but rather as complementary. She stated that electronic health records within an exchange is different from a health information exchange, which is more of a community-wide effort. **Representative Wood** stated that the St. Luke's system and Magic Valley Regional Medical Center (now part of the St. Luke's system) have their own system and asked whether IHDE is going to be a mechanism to enable all these electronic medical records systems to talk to one other, share data with one another, and whether any money received from the grant is going to be spent around the state to get systems connected. **Ms. Larson** answered "absolutely"; IHDE's role is to create an infrastructure to allow that exchange which will help increase quality and coordination of care and, in the long-term, provide leveraging to contain health care costs.

Senator LeFavour wondered if the IHDE model can be sustained under a different fee structure and whether potential participants would be able to afford the existing fee structure. **Ms. Larson** answered that IHDE has a Board of Directors Finance Committee wrestling with the fee issue, but that she did not have additional information on that at this time.

Representative Elaine Smith asked **Ms. Larson** to explain the difference between $30,000 yearly provider fee for IHDE compared to the $10,000 yearly provider fee for the eastern Idaho electronic medical records systems mentioned by **Mr. Huerta**. **Ms. Larson** answered IHDE is a not-for-profit corporation and pricing structure is based on costs IHDE has to pay. The costs to IHDE are transparent.

Senator Cameron suggested that both the IHDE and the PMC could make future appearances before the task force to keep it informed and involved. **Ms. Larson** said she could work with **Mr. Smith** regarding cost transparency and differential. **Senator Cameron** asked for a better understanding of what IHDE is providing; he cautioned about duplicating existing systems. **Ms. Larson** ended by emphasizing that proprietary, closed systems will not be sufficient to meet the federal meaningful use requirements, so the kind of connectivity offered by IHDE is needed.

Ms. Sue Broetje, Administrative Director, Idaho State School and Hospital (ISSH), was unable to attend the meeting due to illness. **Ms. Michelle Britton**, ISSH Division Administrator, Family and Community Services, spoke on her behalf. **Ms. Britton** said that ISSH had received an appropriation last year which included legislative intent asking ISSH to look at its campus to decide how best to discharge all residents back into community settings. This legislative intent requested that ISSH provide descriptions of all clients, identify barriers to moving them into the community, costs, etc. and report back to the germane committees and JFAC during this 2010 Legislative Session.

However, **Ms. Britton** stated that it will still be necessary to admit certain individuals to the ISSH campus. Some individuals have been adjudicated through the court as a criminal but do not belong in the prison system due to disability or very severe, challenging behaviors. A review committee has been put together consisting of advocates, parents, guardians who had residents at ISSH, some department personnel, consumers, first responders such as law enforcement and prosecutors, legislators and community providers. The biggest issue identified is the ability to respond to crisis with regard to those clients who need to be admitted due to behavior. Focus groups have been formed and other states were researched. A proposal is currently being developed which has been submitted to a review committee for comments in preparation for the next legislative session. ISSH will write a report showing the budgets for 2011, 2012 and 2013, and proposing how ISSH might discharge a number of individuals back into the community while maintaining some capacity for treatment and crisis placement. **Ms. Britton** stated that ISSH is for people with developmental disabilities. A number of family members are very resistant to moving their family member (about 35 in number) from ISSH to a private placement.

The proposal being developed might include changing the Idaho Code's description of ISSH's purpose as being limited to serving those individuals with behavior problems in addition to a disability. Along with the proposal, a budget and a work plan for the next three years will also be submitted on how ISSH can arrive at having a campus with 36 treatment beds and eight crisis beds. **Ms. Britton** said that looking forward, there would be a treatment facility and crisis capacity in three regions of Idaho: one in Coeur d'Alene, one in southeast Idaho (Blackfoot or Burley), and continued use of the ISSH campus.

Ms. Britton said the real need is for crisis capacity. Many individuals who call a hospital will not get a mental psych unit; there are no options, because there is no place for these individuals. Jails are not the appropriate placement. Law enforcement is often the first contact. The goal is crisis prevention, crisis response and temporary crisis placement with the discharge of a number of individuals over time and the retention of about 36 beds. The anticipated cost should be approximately what was being appropriated for ISSH prior to the current hold backs. **Ms. Britton** said that the current average federal matching percentage for Medicaid is 69% but could change with federal health care reform.

Representative Wood commended everyone that worked on this ISSH project, coming up with excellent ideas that address the precarious fact that Idaho does not have a mental health or developmental disabilities system. Out of this comes the need for a system which has to be community based; Idaho can do a much better job in taking care of the mental health and developmental disabilities population. These excellent recommendations may have to wait until the economy improves to get funding. Funds are short, but the state needs to act on recommendations.

Senator Cameron said that the proposals made by ISSH will come before JFAC, and he assumed also that presentations will also be made before the Health & Welfare Committees in the House and Senate. He asked whether the ISSH proposals include the possibility of relocating the ISSH campus and potential selling or using that valuable property. **Ms. Britton** answered that the campus issues are separate from service needs. The Director will determine the best use of the campus. The proposal includes retaining some bed capacity on the campus for people with disabilities but has not been settled on the location for the mental health services. **Senator Cameron** said that the ISSH campus property seems to be prime property that could be used to generate revenue for a facility at another less prime location. **Ms. Britton** said that ISSH still has a bond payment due in the amount of $7 million and the $630,000 annual payment is covered by Medicaid that must be dealt with; the proposal includes that bond payment over time.

Senator Cameron asked the task force if they wanted to simply monitor what is occurring at ISSH or if they wanted to think about making a recommendation to the germane committees or joint committees about ISSH.

Senator Joyce Broadsword addressed the task force on insurance company coverage for oral cancer medications. This is about parity - providing insurance coverage for treating cancer no matter the delivery method. **Senator Broadsword** said that while this is a national problem, waiting for legislation at the federal level could take years; she doesn't believe it to be fair to make Idaho constituents wait to have this problem fixed.

Senator Broadsword noted that the task force had previously asked how big of an issue this is in Idaho. Due to the Health Insurance Privacy and Portability Act (HIPPA), cancer centers were not able to give her exact numbers; she hopes that insurers will come forward with that data. In Oregon, following the adoption of chemo parity legislation, there were 79 requests from insurance companies to raise rates, only 9 of which cited chemo parity as a reason for the increase.

Senator Broadsword handed out a letter from Saint Alphonsus dated November 25, 2009 which said, in part: "We are writing in support of efforts to require insurers, when providing coverage for chemotherapy treatment, to provide coverage for prescribed orally-administered anti-cancer

medications no less favorably than intervenously-administered or injected anti-cancer medications that are provided as a medical benefit. Oral chemotherapy currently accounts for approximately 10% of prescribed chemotherapy regimens."

Although the insurers have indicated that there really isn't a problem since most insured patients are provided coverage for oral cancer medications on appeal, **Senator Broadsword** believes this to be disingenuous. She has been contacted by several constituents, one of whom is having an issue with an out-of-state insurance company, which outlines problems that do occur with Idaho residents. This constituent received her monthly cancer infusion treatment therapy ($40,000 monthly) in Seattle, 6 1/2 hours from her Idaho home; when this patient was at home in Idaho, oral medication cost $4,500 monthly. However, her insurer denied coverage. Most people do not appeal since they are not educated as to their rights or do not have hope of winning an appeal. They are afraid to fight for themselves in addition to fighting the cancer. **Senator Broadsword** emphasized the cost difference for the insurance company, believing that the oral agent should be allowed in like manner to infusion therapy.

Senator Broadsword shared that after the November 4, 2009, meeting of the task force, a constituent of hers was suddenly contacted by her insurance company, which had denied her claim in March, 2009, agreeing to pay all out-of-pocket expenses. The constituent had written the insurer a letter but had gotten no response until this information was shared at the task force meeting. **Senator Broadsword** believes this action was in direct response to testimony given in front of the task force. The constituent has requested anonymity, fearing retaliation by her insurance company.

Senator Broadsword handed out draft legislation similar to what was printed last session, adding a paragraph requiring prior authorization by the insurer as a possible solution for passage.

Ms. Susie Pouliot, Idaho Medical Association (IMA), stated that the IMA supports parity for cancer treatment. When insurance is purchased, it is reasonable to expect that oral cancer treatment will be covered, especially when it is the less expensive form of treatment. Sometimes, this is not the case. The IMA met with the Idaho Association of Health Plans (IAHP) and the Cancer Society to try to reach a middle ground. This is a difficult issue since the insurance industry is opposed to mandates regardless of merits of a particular situation, but the IMA is hopeful that this will be addressed. **Ms. Pouliot** noted that insurers have said that 80 of 81 patients going through case management get the oral chemo coverage needed. Yet, the IMA hears that there are people falling through the cracks and not getting necessary care. The IMA's perspective is wanting the most medically appropriate evidence-based treatment to be available for patients who have a policy in place. **Ms. Pouliot** said the IMA is very committed to finding a workable solution allowing physicians and patients the best course of care. If problems exist, she invited the insurance industry to tell the IMA what they need to do, so that physicians can be

advocates for their patients. If there is an appeals process or a way to expedite approval, tell the IMA so that its members will be informed and can be advocates for patients.

Senator Cameron said the dilemma illustrated by **Senator Broadsword's** testimony and in other cases is that insurance companies are out-of-state or self-funded groups and not regulated by Idaho law; whatever legislation might be passed would affect only those 80 out of 81 who are already receiving parity. Individuals also have free choice about choosing plans with limited or no pharmacy benefit. **Ms. Pouliot** answered that with respect to purchasing choices with limited pharmacy benefits, she doesn't believe that there is a patient who thinks they will not be covered for cancer treatment; it is dependent upon what kind of cancer a patient is diagnosed with and best treatment. **Senator Cameron** said when he meets with clients and tries to counsel them, such situations are mentioned, but he finds that price often determines choice. Clients are often willing to take risks. Therefore, he struggles with the role of legislator when people willingly take on that risk and are then discouraged when policies do not fulfill their expectations.

Senator Broadsword asked how long **Senator Cameron** had been counseling his clients about the prescription benefit portion and asked whether he realized that chemotherapy agents were oral at the time this counseling occurred. **Senator Cameron** answered that counseling has taken place since these cheaper plans became available; the industry was encouraged to come up with lower cost plans that eliminated or capped some benefits. He personally has had clients sign a disclosure stating that they understand certain treatments are not covered or are capped. As a buyer, there is a responsibility to understand what is purchased, regardless of product. Self-insuring sometimes results in a dilemma.

Senator Broadsword reiterated that while 80 out of 81 who appealed got coverage, there are many who do not appeal and many who pay out-of-pocket for treatment they anticipate will be covered and is not. This may be occurring with others as well, but they may be slipping through the cracks or are unwilling to come forward. **Senator Cameron** said that legislators cannot tell people what they should or should not do; the initiative to be informed must be taken to some degree by individuals purchasing policies.

Senator LeFavour stated that may people do not use an agent when purchasing an insurance policy and that some agents may not inform clients that chemo is not covered under a certain policy. She believes expectations from the public are that they will be covered if they get sick and insurance companies should better inform clients; she also believes it is a legislator's job to make sure that clients are informed and protected. **Senator Cameron** said that he believes carriers do inform clients about what is covered; few people read insurance policies and some people knowingly purchase a policy with no pharmacy benefits or very limited benefits. When there are alternative treatments that are more cost-effective, insurers will pay for the oral rather than the more expensive counterpart, which he believes to be appropriate. He emphasized there

is no way to regulate out-of-state insurance companies or self-funded groups, where most problems arise.

Senator Corder said that there seems to be two issues: (1) a person who made a poor choice; and (2) the parity issue. **Senator Broadsword** said that her draft legislation provides that oral chemo anti-cancer agents would be treated no less favorably than intravenous treatment and includes a section that allows insurance companies to prior authorize such treatment. She doesn't believe it is fair to make citizens who have a cancer diagnosed in March to wait until October for an insurance company to approve coverage in order to get treatment. Time is of the essence and the appeals process may take 90 days or more.

Senator Cameron said the delay may be for a number of reasons, including obtaining information from the physician or delay in the appeal on the part of the patient. **Senator Broadsword** answered that this patient in question is also an insurance agent who knew her benefits, but it takes time to get the information requested by the insurance companies.

Senator Goedde asked if the Legislature didn't mandate appeals information be included on the policy. **Senator Cameron** said "yes." There is a requirement and a new process where an individual can go to the Department of Insurance for "mandatory external review" and the Department will investigate a situation to create a better system for consumers.

Representative Rusche asked about the draft legislation being focused on oral chemo oncology drugs. He said that these drugs also had other uses for immune disorders and asked if the draft would include those situations. **Senator Broadsword** answered that her draft legislation only deals with anti-cancer agents; no external medications, such as anti-nausea drugs, are included.

Representative Rusche believes this to be about process - getting the information required to make a coverage decision to the insurance companies in a timely manner. He doesn't know of any health insurer willingly paying more than it can absolutely get away with, such as requiring a patient to be treated intravenously rather than the lower-cost oral treatment. He pointed out there are two types of pharmacy benefits: (1) major medical, and (2) pharmacy benefit. Oral cancer medications are not the only expensive oral treatments being developed. He expressed hope that the state can figure out a way for patients to get timely treatment at the lowest cost. **Senator Broadsword** answered that the focus in her proposed legislation is narrowly worded, "when providing coverage for chemotherapy treatment."

Senator Goedde asked if **Senator Broadsword's** proposed legislation defines or specifies the difference between convenience and medically appropriate. **Senator Broadsword** answered that could probably be addressed in rule.

Dr. Richard Rainey M.D., Idaho Medical Director, Regence BlueShield of Idaho, was asked to

address the oral cancer treatment coverage issue. He said that Regence has approved oral chemotherapy as an alternative benefit, which is a benefit for services not otherwise contractually covered but for which Regence may approve coverage after evaluation by case managers and when the services are medically necessary and result in overall reduction of covered costs and improved quality of care. These approvals are on a case-specific basis, and Regence intends to continue to consider requests for coverage of oral chemotherapy as an alternative benefit. This coverage is not built in to existing products.

Dr. Rainey referred to the case mentioned by **Senator Broadsword** and noted that this patient was originally denied as a benefit limitation and that this particular case had not come up as an appeal. After **Dr. Rainey** heard the testimony two months ago, the case was reconsidered by Regence as an alternative benefit and coverage was approved. This case illustrates the difficulty Regence has in identifying members with similar issues. Addressing the problem in this manner is like putting a bandaid on a product.

Regence is being proactive on this issue and is planning new approaches in benefit structures to accommodate oral chemotherapy. An extended formulary is being developed with chemotherapy medications included, both IV and oral. This will be included in a large group product and will be marketed in Idaho with this design as an option on January 1, 2010. Regence intends to market a small group product with this as an option on July 1, 2010. Building these options into the products from the ground up will enable consistency in administration, which has not been the case up to now. Some self-funded plans with unusual designs can be somewhat of a problem, but not so much for Regence, since its plans have not had issues with members, which may not be the case with other self-funded plans.

According to **Dr. Rainey**, the most difficult issue for Regence is individual products with limited coverage of oral medications. These products were developed with the well-intentioned purpose of making health insurance more affordable and to reduce numbers of uninsured. As a consequence, a number of people are on these products that have a low pharmaceutical benefit. An option considered by Regence is to include the extended formulary into small and large-group plans. However, including the extended formulary into individual plans with very low-dollar limits would result in a big jump in premium. Regence doesn't think this will be a likely solution. The option which Regence believes will be more effective is having oral chemo in individual products not be subject to a pharmacy benefit maximum and requiring coinsurance similar to medical coinsurance. This would increase premiums some, but not at the greater amount of the other alternative.

In summary, Regence will very soon actively sell group products that have equivalent coverage as options. Regence is looking into this also for individual products. In the meantime, members with older products will continue to be considered for coverage on chemotherapy as an alternative benefit.

Dr. Doug Dammrose, M.D., Senior Vice President, Chief Medical Officer, Blue Cross of Idaho, said that there has been an ever-increasing list of orally active agents for cancer treatment since they were first approved by FDA in 2001, creating some system issues for member contracts, as well as for the administration of benefits. He believes Blue Cross has met the needs of its members with cancer by approving coverage consistently with their contracts and assuring treatment consistent with national guidelines. **Dr. Dammrose** handed out three documents: (1) "Prior Authorization Chemotherapy Workflow"; (2) "Oral Chemotherapy Coverage"; and (3) "Chemotherapy Drug Process after the Rx Drug Limit has been Exhausted." These handouts are available at LSO. This information was being provided by **Dr. Dammrose** to answer questions raised in previous task force meetings.

Dr. Dammrose went over different medical scenarios and effects of oral medications on different cancers and possible risks. He said that Blue Cross would continue to evolve products and systems to optimize coverage of these agents; in the meantime, patients will be covered appropriately according to national guidelines. He told the task force that mandates for clinical matters are not recommended.

Representative Marriott asked if the cost is equal between intravenous and oral, what is the problem. **Dr. Rainey** answered that, in general, it's not a problem for most commercial products in self-funded groups. The problem has been members whose benefit maximum is limited for any medication filled at a pharmacy; oral chemo treatments hit up against that benefit maximum. It is not a medical necessity decision, but rather a benefit maximum issue.

Representative Marriott asked if BlueShield would pay up to that maximum and **Dr. Rainey** answered "yes." **Senator Cameron** said the issue is what happens after that maximum is reached, having purchased a major medical policy with a small pharmacy maximum. Some clients have chosen to have no pharmacy benefit at all.

Representative Rusche asked **Dr. Rainey** if the extended formulary product is offered as a benefit option, is there worry about adverse selection, particularly in small group products. **Dr. Rainey** answered that this is a particular concern for the individual product. The option that BlueShield is pursuing is equivalent or should be similar to what its competition is offering, so hopefully there will not be that much adverse selection. If BlueShield was not attempting to handle this issue through case management, that would be a valid concern.

Representative Rusche said that when pharmacists put in a code, there is an ability to receive a message back; he wondered if a code isn't accepted for a patient, there is a way to provide notification to the health plan carrier to expedite the appeals process. **Dr. Rainey** said rather than going around that historical appeals structure, BlueShield wants to move forward and offer the coverage as an option to small and large groups. **Representative Rusche** said that the sooner this situation is known, the sooner case managers and clinical evaluation could set up a review.

Senator Cameron asked if offered as a benefit, from a competition standpoint, wouldn't BlueShield rather have all carriers be required to offer that same benefit. **Dr. Rainey** said that BlueShield sees the logic in that but is not ready to say "give me a mandate" at this point. **Senator Cameron** asked **Dr. Dammrose** if Blue Cross was anticipating treatment alternatives as an optional benefit. and if the current system seems to be working for some individuals to have oral chemo, when it is more cost-effective. **Dr. Dammrose** said currently Blue Cross believes patient needs are being met. As the problem is studied further, system issues such as identifying these particular patients early, perhaps could be optimized. Many agents are part of the preauthorization process due to sheer cost and may be better identified in that way.

Senator Cameron said on the group side, employers have the choice to have pharmacy covered under major medical rather than as a pharmacy benefit, and, in most cases, that is a lower-cost product. He asked if there is any consideration to provide similar coverage for the individual products. **Dr. Rainey** said the problem with that is when pharmacy is covered as a medical benefit, there may be a $3,000 to $4,000 outlay up front before any reimbursement is received. **Senator Cameron** said that some clients choose that direction and like the idea of pharmacy benefits going toward meeting a deductible and that in some cases treatment being received helps meet the deductible and is a cheaper product. **Dr. Rainey** said that is the structure of some products and still will be an option.

Senator Stegner asked for an explanation as to why the extended formulary option saves money. **Dr. Rainey** answered that for large and small group products there is going to be an extended formulary where medications in this category (not just for cancer) but other agents are treated similarly whether billed for pharmacy or through the medical benefit in order to achieve consistency. **Dr. Rainey** said this was an option BlueShield could consider for the individual product, but the majority have a low dollar maximum. Most small and large group products don't have low pharmacy maximums, so it is easier to provide for equivalency. In individual products with low pharmacy maximums, if a maximum applies to the pharmacy benefit that doesn't apply to the medical side, there is not true equivalency. In order to achieve true equivalency, the benefit maximum needs to be taken off the pharmacy and this will increase the premium and price it out of the market, resulting in adverse selection. Rather than taking the maximum off across the board, an alternative is to take the cap off the chemo agents treating cancer, so that the lower maximum doesn't apply to those medications, and have coinsurance on those oral equivalents. This would increase the premium some but not as much as across the board. **Senator Stegner** asked if a decision had been made. **Dr. Rainey** said BlueShield is looking at that and there is concern about adverse selection.

Senator Stegner thinks there is significant appeal in the Legislature for chemo treatment coverage equivalency. To walk into a pharmacy and buy $25,000 worth of drugs for a month would be tough for many people. Any attempt to do this on a voluntary basis by offering options

would be difficult for individuals in this particular market with rising health care and insurance costs. **Senator Stegner** doesn't believe there are many companies who will find it an appealing option to pay more, absorb that cost, or pass on to employees. It makes sense to make this a mandate with everyone sharing the cost, which is the whole idea behind insurance in the first place. **Senator Stegner** believes there is significant appeal for this general concept in the Legislature, recognizing that providers do not like mandates, but sometimes mandates make sense. This mandate made sense last year when it was put on hold. The options suggested today do not excite him because it means trusting the judgment of insurance companies to make these decisions rather than medical doctors or patients. He doesn't think there is sympathy for a convenience factor when there is a true savings for a more traditional treatment. If not a significant cost difference, it seems to him that most insured people believe they will be covered for such expensive cancer treatment.

Senator Goedde asked what the differential in premiums would be in offering an extended formulary option to small and large groups. **Dr. Rainey** answered that for the large groups, he was not aware of any actual numbers in Idaho but will know more as July 1st nears, after the bids go out.

Senator Cameron asked what Oregon has experienced with large groups since mandating chemo treatment parity. **Dr. Rainey** said that it was his understanding that the chemotherapy benefit, not the whole pharmacy benefit, increased around 20%.

Senator Goedde suggested this task force look at the effect a chemo treatment parity mandate might have on the high risk pool and the CAT fund.

Senator McGee suggested that another possibility seems to be to put a group together to discuss this issue in further detail. Based on testimony, he believes that a solution can be found to this problem that seems to beg for a solution; it would be valuable to include the insurance company medical directors in such further discussion.

Representative Marriott thought that the prior authorization concept is really an after-the-fact authorization since 95% of doctors have no idea whether a patient is covered for a suggested procedure at the time it is prescribed. **Dr. Rainey** responded that in order for a pharmacy to get paid by the insurance company, the pharmacy will recognize the need for preauthorization 100% of the time. If the insurer is billed through a pharmacy, there is that safeguard. Physicians are somewhat familiar with services they provide and the preauthorization requirements, but not 100% of the time.

Representative Marriott said that this is more a problem in rural Idaho. If the pharmacy is 50 miles away from the physician who writes the prescription and informs the patient that the medication is not a covered benefit, that could be a real inconvenience. **Dr. Rainey** said most

pharmacies in Idaho are in-network. He said when a member obtains a prescription and goes to the pharmacy, not realizing it requires preauthorization, the physician will be contacted. BlueShield publishes online all medications requiring preauthorization. **Senator Cameron** commented that many physicians do not have access to a computer at the moment a prescription is issued.

Senator Broadsword clarified that part of the problem is that most pharmacies do not stock these terribly dangerous, expensive anti-cancer medications unless it is a specialized pharmacy or has been notified far in advance. **Representative Marriott** said that was precisely his point. In rural Idaho specialized pharmacies are not readily available.

Representative Wood said the Idaho Legislature doesn't want to head down the same road that Congress is just about to go down, attacking issues not there and not attacking issues that are there. He was initially skeptical of **Senator McGee's** suggestion of another subcommittee. However, this might be a good idea and thanked **Senator Broadsword** for bringing this issue up. More and more oral agents are being developed for treatment, and the insurance industry recognizes that. These drugs will not be sold for less. Perhaps people having an interest in this issue should meet with health clinics and others to formulate an Idaho plan on how to address this specific issue. A viable solution could then be developed on how to proceed in the state and do it right, rather than going off erratically when a problem arises.

Senator LeFavour protested at **Representative Wood's** politicizing with regard to what is going on in Congress. She also wondered how many attendees are affiliated with an insurance company. When legislators discuss policy, there are many people in a room affected by the issue. She believes it is the responsibility of lawmakers to be very cognizant of that.

Senator Cameron said he tries to vote on issues and not vote depending upon who is physically in a room. He believes that most people around the table are that way. He believes there is lots of politics in the health care reform debate; however, he said he believes that **Representative Wood** has a viable point as does **Senator McGee**. Since there is no current legislation before the task force and in order to move off dead center, **Senator Cameron** invited anyone interested in this matter to form a working group. He was not comfortable appointing a formal subcommittee given the time restraint with session near, but he invited committee members and others to work together and perhaps consider four alternatives: (1) do nothing; (2) full mandate, which may not be acceptable to many given the climate; (3) a preauthorization mechanism that could make the current system more effective; or (4) legislation allowing carriers to address this issue where cost effective. A workgroup should be allowed to meet prior to the next task force meeting with the goal of proposing a solution.

Senator Broadsword said she was not opposed to working with insurance carriers to find a solution, short of legislation, but does not want to take legislation off the table. She liked the

idea of major medical but disagreed with **Dr. Rainey** as to whether a patient would have to show up at a pharmacy with $3,000 to $4,000. At that point a patient is on therapy, has had surgery, is maxed out on all other resources and has met a major medical deductible.

The next agenda item was a teleconference phone call to **Ms. Joy Wilson**, National Conference of State Legislatures, who updated the task force on health care reform nationally. **Senator Cameron** thanked **Ms. Wilson** for her input and she agreed to keep the task force updated with current information.

Senator Cameron said the next agenda item was proposed draft legislation.

Senator Lodge handed out Draft PAP028, relating to opting out of the state immunization registry, a copy of which is available at LSO. **Senator Lodge** pointed out changes in the draft, and invited **Ms. Pouliot,** IMA, to speak to this draft.

Ms. Pouliot stated that the IMA is strongly supportive of this draft and has identified the issue as a top priority. **Ms. Pouliot** stated that the immunization registry is a key component in raising immunization rates in Idaho. Idaho currently has a voluntary, opt-in registry. **Ms. Pouliot** said this change could create more ease and that this draft legislation would be cost-neutral.

Senator McGee moved that the task force recommend the passage of the draft legislation PAP028 brought forth by Senator Lodge dealing with the immunization registry, seconded by Representative Wood and the motion passed unanimously by voice vote.

Representative Rusche presented Draft PAP031, a copy of which is available at LSO, saying this was an update, raising the annual contribution to a medical savings account (MSA) from $2,000 to $3,000. This draft would have an impact to the general fund in the amount of about $1 million.

Senator Cameron asked how many banks and other entities are still offering the state medical savings accounts versus the federal medical savings accounts. **Representative Rusche** answered he did not know. **Senator Cameron** asked if the fiscal impact was based on Tax Commission's assessment, and **Representative Rusche** stated that the general fund impact was based on information from the Division of Financial Management.

Senator Lodge asked if **Representative Rusche's** proposed legislation would be affected by the pending health care reform legislation. **Senator Cameron** said that question needs to be asked and requested that **Representative Rusche** could ask the Tax Commission to provide a firm general fund impact number. If that number is significant, perhaps a phase-in, over time, could be considered. **Representative Rusche** agreed that might be appropriate. **Senator Cameron** said that, in the meantime, the bankers association could poll its members to determine if they were still offering state MSAs.

Larry Benton, Benton, Ellis & Associates, introduced **Ron Rock**, CEO, Northwest Specialty Hospital, Post Falls, Idaho, who addressed an issue for the upcoming legislative session on managed care reform.

Mr. Rock stated that managed care reform legislation is necessary to provide the best possible quality of care at the most affordable rate. Due to resurgence of networks in response to the provider law, a loophole has been created. The proposed legislation seeks to close that loophole. **Mr. Rock** said he has a strong belief in being able to provide the best quality of care at an affordable rate that is equal or lower than competitors and wants to continue to do that without the negative impact on insurance companies or the health networks who are not regulated by the insurance department. This legislation is necessary to compete in that environment.

Mr. Rock said that Northwest Specialty Hospital was recently part of a national survey by Consumer Reports Health, which rated 3,400 hospitals, including eight that, like Northwest Specialty Hospital, are physician-owned. The Northwest Specialty Hospital was rated as No. 1 in Idaho. This overall rating was based on overall patient satisfaction, patient satisfaction with physicians and nursing care, hospital cleanliness, infection rates and cost. **Mr. Rock** said that Northwest Specialty Hospital has repeatedly tried to join the Idaho Health Network and had been denied access to the network. To join the Idaho Health Network, a requirement is that one must become a member of Kootenai Health Network, a subsidiary of the Kootenai Regional Medical Center.

Representative Rusche asked if the draft legislation being referred to was the same as brought forth by **Representative Nonini** last session. **Mr. Rock** replied that it was, with changes. He informed that the legislation has not been fully drafted as yet. **Senator Cameron** suggested that the draft legislation be presented to the task force at its next meeting.

Senator Cameron and **Representative Collins** invited draft legislation be presented in advance to the task force prior to the next meeting.

Representative Wood said it had come to his attention that there may be significant issues with regard to air ambulance service in the state and legislation may be coming forth.

Representative Rusche said he had a proposal to study broad reinsurance scheme, adding that it was premature given the national health care reform taking place.

The meeting was adjourned at 3:53 p.m.