

MINUTES

(Approved by the Task Force)

HEALTH CARE TASK FORCE

October 11, 2010

Boise, Idaho

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

Others attendees were: Senator Joyce Broadsword, District 2; Representative Phylis King, District 18; Suzanne Budge, SBS Associates/National Federation of Independent Business (NFIB); Susie Pouliot, Molly Steckel and Ken McClure, Idaho Medical Association (IMA); Kurt Stembridge, GlaxoSmithKline; Steve Tobiason, Jack Myers and Woody Richards, Blue Cross of Idaho; Benjamin Davenport, Risch Pisca, PLLC; Kathie Garrett, Advocates for Addiction Counseling & Treatment (AACT); Larry Benton and Kris Ellis, Benton, Ellis & Associates; Richard Armstrong, Larry Tisdale, Paul Leary, Department of Health and Welfare (DHW); Tim Olson, Tom Wortman, Georganne Benjamin, Scott Kreiling, and Lyn Darrington, Regence BlueShield of Idaho; Teri Barker, Denise Chuckovich, Jesus Blanco and Tim Heinze, Idaho Primary Care Association (IPCA); Sara Stover, Division of Financial Management (DFM); Bill Roden and Jean DeLuca, Delta Dental; Tammy Perkins, Office of the Governor; Allison Warren, KTRV; John Watts, Idaho Primary Care Association/Idaho Voices for Children; Julie Robinson, Family Medicine Residency of Idaho; Scott Ki, Boise State Public Radio; Sarah Fuhrman, Roden Law Office; Dustin Hurst, Idaho Reporter; Bill Deal, Director, Department of Insurance; Roger Howard, Living Independence Network Corporation (LINC); Jim Genetti and Tom Shores, Idaho Association of Health Underwriters (IAHU); Steve Thomas, Idaho Association of Health Plans (IAHP); Corey Surber, Saint Alphonsus; Norm Varin and Marnie Packard, PacificSource; Ryan Mitchell; Rob Mitchell; Nancy Mitchell; Brian Kane, Office of the Attorney General; Laren Walker, High Risk Pool Administrator; Hyatt Erstad, Idaho High Risk Insurance Pool (IIHRRP) Board; Diane Kopecky, IIHRRP; and Joy Wilson, National Conference of State Legislatures (by conference call).

The meeting was called to order by **Co-chair Representative Collins** at 9:20 a.m.

Representative Rusche moved that the minutes from the January 13, 2010 meeting be approved, seconded by Senator Cameron. The motion passed unanimously by voice vote.

Paul Leary, Deputy Administrator, Division of Medicaid, Department of Health and Welfare, updated the task force on the CHIP B and the Access Card programs. His PowerPoint presentation, "2010 Chip-B and Access Card Update," is available at:

http://www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1011_leary.pdf

Mr. Leary stated that direct coverage for Title XXI children up to 150% of federal poverty level (FPL) is down slightly from 18,115 in June, 2009, to 18,034 in June, 2010; that direct coverage for individuals 150-185% of FPL is down from 7,492 to 7,003; that access card eligible children went down from 46 to 30 in June, 2010; and that access to health insurance went up from 434 (347 adults and 87 children) to 456 (364 adults and 92 children) in 2010.

Mr. Leary also stated that the Preventive Health Assistance (PHA) premium collection total for state fiscal year (SFY) 2010 amounted to \$763,079; that the number of children currently required to pay a premium (\$10 or \$15) was 12,856 in June; that the number of children who earned points for well child checks and immunizations was 22,661 in May; and that the percent of children earning PHA points was 70% in May. PHA points paid for premiums to-date was 1,734,759 (\$1,734,759) and the number of children closed for not paying premiums SFY 2010 was less than one percent (1%). **Mr. Leary** said this is all positive news. He added that the number of employers participating in these health insurance programs was down from 121 to 115, possibly having to do with the economy.

Mr. Leary stated that all brochures had been updated with accurate information. According to **Mr. Leary**, a positive thing about the CHIP B program is that there are 14 full-time equivalent nurse positions in public schools that support the program, and that with health care reform there may be opportunities for schools to have health centers. The budget sheet for CHIP B insurance premium tax fund projections for state fiscal years 2005-2012 can be viewed at: http://www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1011_leary_handout.pdf

Senator Stegner requested more information about total number of nurses involved and whether some are part-time. He also asked whether there is uniform program coverage across the state. **Mr. Leary** explained that the 14 nurse positions represent 16 or 17 schools, some full-time and some part-time. The Department of Education looks at low-income schools without registered nurses with certain criteria for grants. Activities covered include education, some nursing care and important screening that often detects special needs of children that would cost less to treat by simple changes.

Senator LeFavour inquired about the model for funding between the Department of Health and Welfare and the schools. **Mr. Leary** responded that the Department of Health and Welfare provides a grant to the schools.

Representative Wood said it was his understanding, with regard to Medicaid reform and what happens in 2014, that the federal government is going to pay initially 100% for new Medicaid eligibles, dropping down to 90% in 2019. He also understood that there are people currently eligible for Medicaid, but who currently do not receive Medicaid, that will be added to the Medicaid program under the federal health care plan. He inquired at what point do these people start counting. He opined that the state should try to get all those eligible people at least identified, since they might need to be covered later on. **Mr. Leary** deferred the answer to **Director Armstrong**, who was scheduled to present later in the meeting. However, he concurred that **Representative Wood** was absolutely right in what's laid out in legislation. He added that beginning on October 1, 2015, children on the Title XXI program will increase federal

funding by 23 percentage points, which will potentially put Idaho at 100% federal funding.

Mr. Bill Deal, Director, Department of Insurance, addressed the Department's efforts to comply with the federal health care reform. He suggested that the Department be invited to future meetings to keep the task force informed as to continuing events and challenges. **Mr. Deal** said that about April 1, 2010, the Department really became involved with delegating jobs to deal with the federal reform. The health care reform bill, signed on March 23, 2010, has between 2,700 and 2,900 pages and has since turned into 20,000 pages of rules. He understands that the federal reform has been a job creator in Washington, D.C. Moving forward with the responsibilities delegated to the states, implementation time lines have been very short, i.e. updating the web portal within three weeks and making changes in the high risk pool within three months. The Department of Insurance has six senior staff members who are devoting about 30% of their time to the federal reform, in addition to their regular full-time responsibilities. The Department is spending about 7 hours weekly in conference calls.

Mr. Deal said the Department is getting filings from insurance companies with increased rates and coverage changes that are a big change from what insurance policies have provided in the past. During the planning stages of the health exchange over the next three years, the Department will be spending about \$2 million, even with grants. **Mr. Deal** said that he and **Director Armstrong** are partners working together for this reform. The Department of Health and Welfare, particularly the Medicaid division, will carry a very heavy workload in this reform, particularly in the exchange area. Soon after reform began, the Department of Health and Human Services (HHS) asked each state to help build their web portal and to provide statistical information, rates and policy provisions for the health insurance companies that are selling products in Idaho. The states were given three weeks to get that done. The same information was requested from these health insurance companies. As a result, the HHS website has a more transparent look at policies and prices available in Idaho.

Mr. Deal said that the second big challenge was the federal high risk pool, now called the pre-existing conditions insurance plan (PCIP). Idaho was given a choice of operating its own pre-existing insurance plan or defaulting to a federally run plan. After researching this issue, the determination was made that Idaho had not been allocated enough money to run this plan for 3½ years, until the other provisions of the federal reform go into effect. Idaho now spends about \$1 million monthly, paying claims in its High Risk Pool for about 1,500 people enrolled. The \$24 million assigned for 3½ years would not work for Idaho, for an expanded program. The recommendation to the Governor was that the pre-existing insurance plan be run through HHS. By the end of August, 3,000 Idaho citizens had applied for the federally run pre-existing insurance plan but only six policies have been issued. Current statistics are not available from HHS on the national enrollment numbers. A good website is available, as well as online applications.

Mr. Deal said that the Department was challenged applying for federal grants, adding that the first grant required about 300 hours. He said that the Department of Health and Welfare was more experienced at grants, so the next grant applications will be easier. **Mr. Deal** said that the Department's first grant was for \$1 million, awarded in August, for premium review. With this

grant, the Department is thrust into a new job of sending all rate filings to an actuary for review to ensure that rates suggested and filed in Idaho meet HHS requirements. Another \$1 million grant, awarded to the Department on September 30th, was for health exchange planning. The qualification portion of the exchange provides that citizens at 133% or less of the FPL will go to Medicaid for their insurance, with those over 133% to 400% FPL will receive subsidies to pay for their health insurance.

Mr. Deal said that Utah has had an exchange functioning for about two years, and Idaho could look at this model. He said he and **Shad Priest** would be meeting with people from the Utah exchange soon and parts of that exchange might be used in Idaho. The Department has broken down the exchange into four phases. These phases must be approved by January, 2013. The phases are: (1) design, administration, public development and public outreach; (2) strategy development, selection and coordination with carriers; (3) implementation (to be met by January, 2013), including actuarial evaluation and product design; and (4) completion by 2014.

Mr. Deal said that we know the exchange will be here and will provide the means to collect and distribute insurance moneys. In doing so, it must provide transparency. The states have been assured that they will have flexibility. The Department wants to make sure insurance companies in Idaho, who are the backbone of health insurance, have the opportunity to maintain good structure on the private side, as far as marketing is concerned. There is great concern among the producers that their role may be eliminated by the exchanges, so the Department is working very hard to develop flexibility so that health insurance producers play an important part as we move forward with the exchange. **Mr. Deal** said it is his personal viewpoint that it is essential to have professional, licensed and trained producers involved in this process. A possible solution is perhaps changing state law to require that an agent be a part of this whole issue. From a regulatory standpoint, we must have producers who are licensed, trained and over whom the Department has regulation authority. These issues will be foremost as the Department moves forward with the exchange.

Representative Collins asked whether the issues of good private insurance company structure and the inclusion of producers in the exchanges are high on the priorities of other states as they develop exchanges. **Mr. Deal** responded that he had recently met with western zone insurance commissioners and the primary topic of that meeting was health reform and how to work together on a regional basis in planning the administrative part of the exchange. It makes very little sense to him for 50 different states to figure out this exchange administration, so the producer part of this program is essential. One of the problems to confront is the fact that there are some companies that use the internet to sell their product that may not understand the value of the producer in explaining options. This is deeply removed from the traditional way to sell insurance. The National Association of Insurance Commissioners (NAIC) has taken a strong position on this issue.

Senator Cameron addressed some of the challenges that will be forthcoming, mentioning that **Paige Alan Parker**, Legislative Services, is working on getting a representative of the Government Employees Health Association (GEHA) that is running the federal PCIP scheduled to come before the task force in November. He said there is confusion since Idaho has a state

high risk pool. The federal high risk pool is called the federal PCIP. Our law requires an insurer to offer the state high risk pool, so if a consumer wants to purchase coverage under a traditional plan and if the carrier decides not to take the consumer based on health conditions, by law the carrier has to offer the consumer the state high risk pool. This has worked fine until now. The dilemma is that this consumer may be better suited to be on federal PCIP, rather than on the state plan. On top of that, state resources are being spent, instead of federal resources that are potentially available.

Senator Cameron asked if **Mr. Deal** had any thoughts about this in his discussions with federal partners on how the state might work through this to make sure Idahoans have the opportunity to utilize PCIP. **Mr. Deal** said this topic has taken up about one month's work time. The Department is working through NAIC to discuss this issue with the Department of Health and Human Services (HHS) and GEHA. The federal partners have used the existence of the state high risk pool as grounds for not issuing PCIP policies. **Mr. Deal** thinks the Department now has an agreement that allows insurance companies issue a declination letter that permits consumers to qualify for PCIP. This is one of three criteria necessary, the others being no insurance in past six months and a pre-existing condition.

Senator Cameron said that Idaho had a choice on whether to participate and run the federal PCIP, and Idaho chose not to. He asked **Mr. Deal** to inform the task force stating the reasons for that decision. **Mr. Deal** said this subject caused lengthy debate back in April before the recommendation was made to the Governor. Some premises discussed were: (1) the high risk reinsurance pool, as it operates today, has between 1,400 and 1,500 enrollees at a monthly claims cost of \$1 million. The states were allocated \$24 million for PCIP claims over a 3½ year period. Mathematically that did not pan out. Statistics showed that possibly 5,000 people in Idaho could be eligible for the PCIP pool, and there would not be enough money to pay those claims; (2) with no money, the state would be forced to cap the plan for coverage on the first 1,500 or 2,000 people; (3) the cost of setting up the plan was a consideration; (4) HHS did not have the ground rules available until a few weeks before the plan was to be implemented; and (5) in the long-term it made much better sense, since the 3½ years was a temporary period until the rest of the federal health care reform takes effect.

Senator LeFavour commented that even though Idaho insurance companies do not issue denial letters and must offer the high risk pool people may still not be able to afford coverage. **Mr. Deal** answered that if a person is not eligible for a "main street product," the insurance company is required to offer a rate in the high risk pool. In some cases the premium is much higher, but studies show that Idaho's premium cost for the high risk pool is one of the lowest in the nation. Million dollar limits are being exhausted, so premiums have to be higher. Availability, he said, was the issue. **Senator LeFavour** emphasized that some people seeking coverage can not afford premiums, hoping that as the transition takes place, premiums can be made affordable. She wondered if the federal option would be more affordable. **Mr. Deal** said that both the Idaho high risk pool and the federal PCIP premiums are based on age. Although the PCIP premiums are incrementally lower, affordability is a problem. Even though health insurance costs are high, IRS data indicates that Idaho has the lowest insurance costs in the nation. Idaho might be one of the

states where rates are going to increase because of the richer coverage provided in policies.

Representative Rusche inquired about the stress level on the Department of Insurance staff to integrate all aspects of health care reform, wondering if the Department is structured advantageously. **Mr. Deal** said that this next year and possibly into 2011 and 2012, the Department can continue the core of responsibilities and contract for needs with regard to the exchange, perhaps with the help of grants. Long term, starting in about 2012, the Legislature and the Department have to make a decision whether Idaho wants to maintain a strong, state-based regulatory department. If so, then the Department is going to have to be allocated at least 3-4 additional staff with a higher level of education, including an actuary. Otherwise, more regulatory authority will move to the federal level.

Representative Rusche agreed, adding that Utah currently collects data through their health information base network. He wondered if that would be something for Idaho to look at. **Mr. Deal** said that Utah has a transparency piece, much like we have in Idaho under “Healthy Idaho” on the Department of Insurance website to review coverage and premiums, which is required in the new model. Utah doesn’t have a qualifier. He believes that Idaho has the potential to develop that piece through the Department of Health and Welfare. He said Utah has an aggregator where money is taken from the employer and employee and distributed to insurance companies. That is a really important piece because when a couple each works for a different company, each will provide a company subsidy and this mechanism must be added up and the money divided where it needs to go. He doesn’t understand why HHS or NAIC doesn’t develop a uniform model, rather than asking each of the 50 states to reinvent the wheel.

Mr. Laren Walker, High Risk Pool Administrator, spoke next. His handout can be viewed at: http://www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1011_walker.pdf

Mr. Walker believes there is much confusion about why the state high risk pool exists and the purpose for it currently and until at least 2014. Because an individual can not have coverage for six months to be eligible for the PCIP, the state high risk pool helps those individuals who come from other coverage.

Mr. Walker shared that, as of June 30, 2010, the Idaho individual high risk reinsurance pool had assets of \$18,503,160, and this is the first year this number has started to decline by about \$4 million. Program expenses are currently outpacing all revenue sources. Total liabilities amounted to \$20,433,627, leaving a negative fund balance of \$1,930,467. Claims paid out amount to about \$1 million monthly, and full year expenditures for 2010 are projected to be \$15,095,000, with a fund balance of negative \$5,900,000. **Mr. Walker** said that the pool covers 1,578 people currently, and over 8,000 individuals have been covered in Idaho by high risk products. **Mr. Walker’s** perspective is that the pool is running very well and that the Board of Directors does a great job. One weakness might be in publication of the product, since he fears that people in Idaho do not know about the program. The Board has made an effort to hire publication specialists so that the public and insurance agents will know about this pool.

Representative Collins pointed out that the task force would appreciate knowing about claim amounts paid by the pool. **Mr. Walker** summarized that the Board monthly looks at a report of

claims over \$50,000 and at lifetime maximums. There are three individuals who hit their million dollar maximum. The Legislature addressed this issue by allowing those individuals to switch to another carrier, allowing the lifetime maximum starts over. Claims cover many illnesses, both genders, and ages 6 to 60. The high risk pool offers five plans. The Health Savings Account (HSA) Plan was introduced in 2007 and is increasing in use. The Base Plan is not used. Usage of the other plans has been basically flat.

Representative Rusche noted the decline in revenues since 2006, and asked if that was due to premium tax rate or the dollar amounts of insurance written. **Mr. Walker** said there has been a phased in decline in premium tax rates. **Senator Stegner** added that the biggest single factor in the last five years has been the reduction in dental insurance premium tax rates as well as a restructuring of premium taxes for all insurance. **Senator Cameron** explained that an out-of state dental carrier had to make an in-state investment in order to get a reduced premium tax was ruled that inappropriate by the court. For some out-of-state carriers in a premium tax reduction, but for other carriers that resulted in an increase in the amount of premium tax paid. The goal was for this to be revenue-neutral each year through the five-year adjustment; but as it turned out, ended up being a reduction in premium tax collected by the state. Therefore, there has been a slight reduction in money received in the high risk pool and the access card program. After a two-year battle, the Legislature decided that on all dental policies there would be a per-head tax, rather than a percentage of overall premiums.

Representative Rusche asked if grants could be expected to make up the shortfall under health care reform. **Mr. Walker** answered that the pool was not sure it would get federal grant income under the new federal health care reform. Other revenue options would be to increase premiums with the burden placed on the consumer, or to increase the assessments to the carriers with a broader spread of risk to all carriers. **Mr. Walker** handed out copies of a brochure entitled “Individual High Risk Reinsurance Pool Plans for Idaho Residents,” which is available from the pool. A copy is available in the Legislative Services Office. In the long term, **Mr. Walker** is unsure of the need for the state high risk pool once the federal health care reform is fully implemented.

Mr. Hyatt Erstad, Idaho High Risk Reinsurance Pool Board, said that he and **Senator Cameron** had attended the National Association of State High Risk Pools earlier this month, and said that Idaho’s pool is running very well and is the envy of many other states. He said that twenty-two states are going to opt out of running the PCIP, primarily because the federal government can not provide answers to the question of what happens to states if federal money runs out before 2014. Only six Idahoans are currently enrolled in the PCIP.

Mr. Erstad noted that the Board was thrilled about **Mr. Walker** and **Joan Krosch**, Department of Insurance, pulling together the grant money received. The pool runs very well and Idaho has done a great job making coverage available. **Mr. Erstad** believes that in 2014 the health care system, as we know it, will be completely different. Under that reform, many larger employers pay the penalty and allow their workers to go into the exchange and receive subsidies.

Representative Rusche asked if the high risk pool is going to be in violation of federal law for its million dollar maximum. **Mr. Erstad** replied no, Idaho’s high risk pool is not subject to

those mandates or removal of those limitations.

Senator LeFavour commented that Idaho offers bare bones coverage when other states have more robust coverage and asked if the envy of other states is due to low costs or bare bones coverage. **Mr. Erstad** answered that in funding high risk pools, Idaho is one of few pools adequately funded. Many states are forced to cut off enrollment to the pools due to lack of money; Idaho is financially solvent and has not had to cut off membership. He said that he believes Idaho has very robust coverage, even though it does not provide for drug coverage and not as much preventive care. **Senator LeFavour** said she worried about people going bankrupt and whether they can they afford fundamental coverage. She is also concerned that people in the high risk pool will be at greater risk without preventive care services. **Mr. Erstad** said he understands, but the High Risk Pool Board is restricted as to what coverage is in policies due to the rulemaking process. Preventive care is available under the PCIP. Preventive care could be added by the Legislature, but the Board is limited as to what they can do.

Mr. Richard Armstrong, Director, Idaho Department of Health and Welfare spoke next. His PowerPoint "Funding Idaho Medicaid" can be viewed at:
http://www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1011_armstrong_medicaid.pdf

Mr. Armstrong gave a history of American Recovery and Reinvestment Act (ARRA) funding impacts, starting back in 2009. The enhanced Federal Medical Assistance Percentages (FMAP) under ARRA have assisted the general fund requests for Medicaid for SFY 2011. However, a drop in the FMAP in SFY 2012 presents a cliff. He projected a \$168.8 million shortfall in general funds for SFY 2012. Such a shortfall will require cost savings of approximately \$542 million or about 30% of Medicaid's projected Trustee and Benefit expenditures for SFY 2012.

Senator LeFavour asked if there is a notification requirement for Medicaid. **Richard Schultz**, Health and Welfare Department Deputy Director for Health Services answered that temporary rules will go into effect in December and that a letter was sent to legislators, putting them on notice of those temporary rules. If those temporary rules are not extended for next year, come July 1, the deficit will be another \$7 million. **Mr. Schultz** explained that there have been no temporary rule changes to this point that affect the budget; the temporary rule changes that were developed over the last few months as a result of the conversation with providers will be implemented in December. The temporary rules go into effect without legislative action by virtue of authority given last year. If the Legislature does not affirm and extend those temporary rules beyond July 1, they will sunset July 1 and \$7 million in savings will be lost. **Senator LeFavour** asked if these rules address rates with providers and the answer was "yes."

Representative Rusche asked about the maintenance of effort (MOE) requirements that Medicaid has under the ARRA. **Mr. Leary** responded that two pieces of legislation, the ARRA and the Accountability of Care Act, impact the MOE. A MOE on eligibility is required to get the increased FMAP under the ARRA. Under the Accountability of Care Act, MOE is required until 2014.

Representative Rusche asked about the adequacy in pricing as well as access. **Mr. Leary**

answered that Access is covered under the Social Security Act.

Representative Elaine Smith inquired about a tragic shooting that had occurred in Pocatello, possibly due to medications and mental health services being cut off. **Mr. Armstrong** responded that this was a very tragic situation. He explained that adult mental health services have been reduced by 20% due to budget constraints. When it became necessary to reduce the number of mental health workers in the field, a process took place of informing individuals served that had other insurance that theoretically they had the ability through that network of providers to receive services. The Department of Health and Welfare has a plan in place to identify and visit with these individuals personally about what will happen. Individuals with no other source of health care were not abandoned; those with no other means must truly have a safety net. In this particular case, the existing caregiver bonds appeared to be strong. It appears that there seemed to have been a dependence between the caseworker and this particular individual. Right now, Medicaid is \$1 million over budget. The Department is trying to make this transition work and is struggling with how to cover this deficit.

Representative Smith asserted that contacting the individuals is not enough and asked if the Department knew whether there was someone who could step in and provide the services in this situation. **Mr. Armstrong** replied that when an individual can't reach out, that the Department tries to reach out to them, but in this case, it did not appear that risk existed due to miscommunication. The goal is to protect the health and safety of our citizens, and there are hundreds of these cases being managed right now. Communication between individuals is very hard to predict with regard to mental health issues.

Mr. Armstrong went on to discuss the task force implementation of the Molina claims system for Medicaid. His PowerPoint presentation entitled "MMIS October Update" can be viewed at: http://www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1011_armstrong_mmis.pdf

Mr. Armstrong stated that 90.2% of claims submitted to the Molina system currently match to coding/configuration. This is up from 75% in July. He explained that this is an educational process that has been very robust across the state. Providers must be taught how to code claims properly for payment. He said that historically there are about 146,000 claims received weekly and a \$24 million payout weekly. In October, \$40.5 million was paid on a total of 181,338 claims. He pointed out that as of October 3, 101,863 claims had not been paid. In June the Molina call center had 17 service representatives. That number has increased to 69. The queue time in July was 38 minutes; as of October 3, the queue time was down to 2.25 minutes. **Mr. Armstrong** said that of the 18 key issues that had originally been identified and prioritized, six have been completed; twelve items remain with targeted completion dates.

Representative Collins asked why the change was made at this particular time. **Mr. Armstrong** answered that the change had been planned for a year ago and that the process started six years ago. The mission was to upgrade and modernize the system. The federal government was seeking a uniform hardware and software system. However, a number of issues delayed the conversion date, including budget issues and the sale of the vendor by UNISIS to Molina. Federal funding for a new system was paid at 90% and the Department needed to make use of the

funds. Timing got pushed out due to a “perfect storm.”

Senator Cameron said he did not believe **Mr. Armstrong** had created this problem and that he knew he would do anything within his power to fix it, if he could. In his conversations with providers, **Senator Cameron** said that he has heard that the system is not getting better, and that the call center statistics, although improved, may be much higher, now 40 minutes, down from 3 hour waits. His understanding is that the system is unable to track any additional adjustments since last April, which was a guess then and an even bigger guess now. Several hospitals in his region are holding claims or have accounts payable in the millions of dollars range, one alone \$20 million, with some claims unable to get into the system He asked: (1) do the large number of claims beyond 30 days risk no federal match or a reduced match; (2) with regard to budget projections, where will the state be with Medicaid enrollees; and (3) how will these affect the Department’s budget request?

Mr. Armstrong answered that the penalties apply only to clean claims that go unpaid for 30 days. The Department has not been subject to claims delay penalties at this time. The clean claims are going through rapidly. Ninety percent of the claims go through without human interaction. The budget is based on the older inventory numbers being used for forecasting. The Department hopes to get more accurate numbers. The forecasts have been amazingly accurate, but the Department understands that it needs to track the changes in health care utilization. The Department has made advanced payments on receivables to assist providers. The amount of inventory outstanding seems to be less; every provider will have a receivable inventory in process, but the claims flow is improving.

Senator Stegner said that complaints were now several weeks old, and that apparently out of frustration, the Molina system was sending checks without proper documentation with regard to what claim the checks were for creating tremendous tracking concerns. He asked if this was being addressed. **Mr. Armstrong** replied “yes” and said that the Molina system sought to match up remittances to claims, sooner or later. The effort to make early payment on claims has resulted in some overpayments. Providers have returned overpayments. Another dilemma, he said, was that one provider submitted 600 claims four different ways, resulting in 2,400 duplicated claims.

Senator Stegner noted the Department’s October 3 target of 90.2% of claims received being accepted (still leaving 166,488 claims not accepted), and asked what might that percentage be if the Molina system was operating normally. **Mr. Armstrong** answered that, with regard to electronic claims, 98% to 99% acceptance would be normal. Paper claims slow the process to 80% and those claims bring down the overall number accepted to 90.2%, adding that the Department has about 19,000 providers, which vary in size and billing sophistication.

Representative Marriott asked what “core defects in the Molina system” meant. **Mr. Armstrong** explained that there was a significant problem in that the system is set up for monthly transactions but providers are billing weekly. This “core defect” should have been detected earlier. He didn’t know why the state, historically, allowed weekly billings. The system is configured by humans and reality and logic in some cases did not match up and needed to be

changed.

Representative Marriott asked why problems were not detected before the conversion occurred. **Mr. Armstrong** answered that in the testing process, 99% of test claims were completed, but the configurations were not right. Molina was understaffed and not properly trained and the system was not configured correctly, with major mismatches taking place, thus creating the crisis.

Representative Marriott asked why actual claims were not used as test files before the conversion. **Mr. Armstrong** replied that it was not in the budget, adding that there are many agencies walking a tight rope without a net, since it costs millions for a live parallel. He said that old claims should have been paid out of the old system, admitting this was a mistake. He said the Molina system will become a stable system in a short time.

Senator Cameron thanked **Director Armstrong** and **Leslie Clement** for their quick responses to his inquiries, adding that he was not so sure about Molina. At one point, the Department made the decision to withhold payment from Molina until issues were resolved, asking if that was still in effect. **Mr. Armstrong** answered that the Department is involved in a legal process regarding deficiencies, but that some payments had been released for operations, following guidance of purchasing. Molina is engaged in that process.

Representative Rusche commented that he had seen system changes before and that this conversion was not as bad as it gets. He added that inaccurate claims information impacts budgets. **Mr. Armstrong** agree and stated that the Department has a contract to review the claims information.

Senator Lodge commended the Department staff for making sure that emails and questions were taken care of quickly to get applications filed by her constituents. She mentioned that some states are 150 days out on payments, so she thinks that the Department is doing very well here in Idaho, even though the perfect storm this summer did affect everyone. **Mr. Armstrong** agreed that this conversion was the Department's misery and the Department is trying to pull it together in the next three months. The Department meets weekly with Molina to address critical issues.

Mr. Jack Myers, Chief Financial Officer, Blue Cross of Idaho, presented next. His PowerPoint presentation can be viewed at:

http://www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1011_myers.pdf

Mr. Myers informed the task force that he met with Director Deal soon after the health care reform was signed. The 2,700 page bill does not contain all the details and all the implementing regulations are not out yet. Blue Cross has over 100 people involved in implementing the reform, plus another 15 spending one-third of their time since March 23 getting ready for this reform. There is much more to do before 2014. He recognized the burden this has placed on the Department of Insurance. **Mr. Myers'** presentation covered near-term provisions; time line for changes; grandfathered plans; high risk pools; dependent age; no pre-existing waiting periods; medical loss ratios; benefit changes; essential benefits; annual/lifetime limits; preventive health; price impact of near-term changes (small group plans and individual policies); other price and benefit impacts of near-term changes on individual policies; additional impact of near-term

changes for new policies; benefit changes; insurance changes; and rate change examples in 2014.

Representative Rusche asked whether the cost shifting on the cost of providing for the uninsured to commercial insurers would be impacted by federal health care reform. **Mr. Myers** said that there was no factor for what providers may do with regard to the uninsured market, so that may have a positive impact.

Representative Collins inquired where the fees charged on insured policies will go. **Mr. Myers** said those fees go to the federal government. **Representative Collins** commented that those fees would likely be transferred to policy holders.

Senator Corder asked why Idaho opted for the federally run PCIP, while keeping its own high risk pool. **Mr. Myers** replied that the PCIP ends in 2014 and if Idaho is going to continue its high risk pool, it needs to keep it as an ongoing program. **Senator Cameron** added that the federal PCIP requires that applicants can not currently have insurance coverage, which is not a requirement under the state high risk pool, and federal dollars the state would receive under a state run PCIP system would not cover what the state is currently spending. Individuals who currently qualify for the state system, can not qualify for the federal system.

Senator Corder assumed that not every state had a high risk pool, and asked what would happen to the body of people in the federal system after that expiration. **Senator Cameron** answered that it is a huge question; not every state has a high risk pool and there are many types of combinations. He said there is no answer as to where funding will come from and whether it will exist after the three-year period of time. He believes that Idaho does need to keep the high risk pool, at least for now, since some individuals can not qualify for the federal PCIP. The state may need to adjust qualifications in the future. **Senator Corder** asked whether the exchange was to fill the role of the high risk pool. **Senator Cameron** responded that the exchange should be up and running by 2014 and individuals with pre-existing conditions should get coverage through the exchange.

Senator LeFavour asked whether the cost ratios create an incentive not to lower provider costs. **Mr. Myers** said that is a fair point, but he believes that market forces will control. He added that the federal health care reform does not address health care costs.

Senator LeFavour commented that 5.7% paid to insurance brokers seems like a lot and asked what would be the effect if an exchange is implemented. **Mr. Myers** answered that he had heard discussion about the need for the continuation of broker consultant services since health care is so complex. All of this would be much more understandable after 2014, when members can go to a website for information.

Senator LeFavour asked whether there was any way for Idaho to do something different to bring the administrative costs down. **Mr. Myers** said that there is always room for health care efficiency on both the carrier and provider sides. Blue Cross will work with providers and encourage electronic transmission of applications and claims versus paper. Having the four standard benefit packages as provided for under the federal health care reform may also improve

efficiency.

Senator Cameron commented that he did not remember the exact dollar amount, but the impression was that brokers do not make a percentage on the initial policy but rather a fixed dollar rate per insured. His recollection is that the commission is about \$23.65 per insured. **Mr. Myers** replied that was correct.

Senator Cameron said that the important point is how consumers are being affected by health care reform. The way Blue Cross seems to have adapted to health care reform is through benefit adjustments, which concerns many consumers since these changes are not seen as improvements in overall benefits. **Mr. Myers** answered agreed that is the Blue Cross approach. **Dave Hutchins** of Blue Cross stated that one plan provides for a \$5,000 deductible for drugs and medicals. He said they looked at other ways to hold premiums down, adding that some want a richer benefit package for a higher premium.

Senator Cameron said that consumers think that nobody would be forced to drop their coverage but in reality, some carriers are eliminating products purchased and are planning to transition that consumer to a similar product. By doing so, the grandfathering status of the existing policy would be lost. He asked if this was the case with Blue Cross. **Mr. Myers** said some policies with a limited number of members and with low benefits have been eliminated due to the potential for higher premiums.

Representative Rusche asked what the overall premium trend was for small group policies. **Mr. Myers** answered that the premiums have been increasing around eight percent a year in prior years and went up five to six percent last year due to the recession. Over the past four months the trend is back to eight percent. This is due primarily to utilization and provider costs.

Mr. Tim Olson, Director, Legislative Affairs, Regence BlueShield of Idaho, next introduced the new President, Regence BlueShield of Idaho, **Mr. Scott Kreiling** and **Tom Wortman**, Vice President, Actuarial Pricing, Regence BlueShield of Idaho. **Mr. Kreiling's** PowerPoint presentation can be viewed at:

http://www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1011_kreiling.pdf

Mr. Kreiling stated that Regence BlueShield of Idaho is nonprofit, committed to serving individual and group customers since 1946. Regence paid taxes in the amount of \$1.7 million last year. Regence has discontinued plans with one to 99 employees, since it does not want to put administrative burdens on these plans.

Mr. Kreiling shared immediate reform impacts in benefit changes for plans issued or renewed on or after September 23 as: added preventive services with no cost sharing; no pre-existing exclusions for under 19; extended child coverage up to age 26; removed overall lifetime maximum; and an early retiree reinsurance program. Regence helped large employers submit applications to HHS and will support ongoing data analysis and reporting necessary for federal refunds. The Web portal has a November target for displaying Idaho individual products. **Mr. Kreiling** said that Regence has new requirements for level of appeals and new explanation of benefits (EOB) data requirements, varying degree of rate increases by line of business, and market

confusion as we all work with incomplete or late-developing guidance. He shared future reform impacts and ended his presentation by saying that Regence shares the community's concern over the high cost of health care, that they have been active and vocal supporters of health care reform and are committed to implementing federal reform as quickly and efficiently as possible. Regence will continue to work with partners in the provider community to find ways to lower costs and improve efficiencies and to make health care more affordable and understandable for individuals and their families.

Senator Cameron commented that some consumers are frustrated by the elimination of their existing plans. Some carriers in other states have discontinued selling policies to children.

Senator Cameron asked Regence and Blue Cross to explain what stance has been taken on providing children's coverage since federal reform.

Mr. Kreiling answered that Regence does not ever, on purpose, slow up a process on an individual applicant, over any other applicant; Regence does not have a pick and choose process. Regence currently offers a HSA child only plan. When Regence looks at products and plan designs, the challenge is to be a viable carrier in this marketplace. **Mr. Kreiling** said that we are a community and we're all in this together. He believes the best thing that has happened is that through reform, everyone will be covered. The challenge is to keep premiums affordable, which is hard when the carrier can not adjust for risk. There will be shifting of costs from hospitals since uninsureds will be covered, admitting it is a complicated situation and there are tough decisions to be made.

Mr. Myers of Blue Cross believes that the only situation where Blue Cross has said that a child has coverage elsewhere is through Medicaid. He is not aware of any slow down by Blue Cross in processing child only applications. Blue Cross has seen an increase in these applications. Blue Cross has no plans to deny coverage for children.

The next presenter was **Brian Kane**, Assistant Chief Deputy, Idaho Office of Attorney General, who was asked to address the current status of the states' lawsuit on federally mandated health insurance. He said that a decision is pending on the Department of Justice's motion to dismiss the lawsuit by the states on jurisdictional grounds. That decision should be out by October 14. If the motion to dismiss is denied, the merits hearing has already been scheduled for December 16. The Idaho Office of Attorney General will be filing a motion for summary judgment. **Mr. Kane** said that the state of Idaho at this point has spent approximately \$6,000 in pursuing this litigation and has been able to achieve some very sizable economies based on the fact that there are about 20 other states who joined together to keep costs down. Other cases worth tracking he said is one in Virginia, where a federal judge has already denied the Department of Justice's motion to dismiss for lack of standing. In Michigan last week, **Mr. Kane** said that a judge has upheld the mandate to purchase insurance. That case, brought by three uninsured plaintiffs, is being appealed. There is potential that three decisions will be made by three different circuits which increases the likelihood of a split among the circuits and a Supreme Court decision.

Senator Stegner stated that from comments made today by the Department of Health and Welfare, the Department of Insurance and the carriers it would seem that everyone is trying to

meet the insurance mandate. **Mr. Kane** answered that, at this point it is the law of the land.

The last presenter, **Joy Wilson**, National Conference of State Legislatures, informed the task force about efforts of state governments to comply with the federal health care reform. Ms Wilson stated that the exchanges require legislative activity. States have approached this matter in a variety of ways, including setting up task forces of various compositions and holding hearings. She stated that the NAIC has a model act for exchanges, which provides a good starting point. Funding of the state exchange is an issue. After 2014, they will be self-sustaining. The authority of the exchanges to regulate is of concern. Compacts between neighboring states on exchanges may be a possibility. She noted that modifications in state regulatory law may be required to comply with federal law. One issue is whether state insurance commissions have the authority to enforce federal law. There are no federal dollars for an eligibility upgrade. The National Conference of State Legislatures has recommended that HHS establish a template regarding the eligibility system. To date, there is not many details on the waiver process. The audio link to her presentation is on our website at:

www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1011_wilson.wav

Senator Stegner asked about the model act for the exchange. **Ms. Wilson** explained this information was on the NCSL Federal Health Care Reform page and also on the NAIC website.

Senator Stegner asked about the small state compacts to join and negotiate. **Ms. Wilson** answered that each state in the compact would have to pass the same law to basically create a market and negotiate with carriers to participate in the exchange, which would create a multistate exchange. The more bodies you have, presumably the more choices you would be able to offer constituents.

Representative Rusche asked about how states communicate in the informative process. **Ms. Wilson** said that most governors have some sort of working group made up of all agency heads having any part of health care reform. Sometimes they also have a stakeholder group that has some meetings with this advisory group with key legislators on these panels. HHS is almost requiring this. **Representative Rusche** asked how these activities are funded. **Ms. Wilson** said that most are working off existing appropriations. In some cases legislatures have, through legislation, ordered the governor to undertake this effort and report.

Representative Collins asked if there was any criteria for waivers. **Ms. Wilson** answered that the criteria is that your constituents can not lose coverage by being part of the state alternative program. Legislation has to be passed. This can not be done by executive order. Right now the key criteria is that constituents must be equally served by the alternative program as they would be by the existing law. **Ms. Wilson** said there was no template yet. Waivers currently are not available until 2017, but some sort of process may be available for legislators in 2012-2013. She added that some in Congress want to move that waiver date up from 2017 to 2015 or 2014. Senator Ron Wyden of Oregon is the sponsor of that legislation.

The task force scheduled the next meeting for November 22, 2010. The meeting adjourned at 3:50 p.m.