MINUTES

(Approved by the Task Force)

Health Care Task Force
August 22, 2011
Capitol Building
Auditorium, West Wing, Room 2

The meeting was called to order by Co-chair Senator Dean Cameron at 9:00 a.m. Other committee members present were Co-chair Representative Gary Collins, Senator Joe Stegner, Senator John Goedde, Senator Patti Anne Lodge, Senator Tim Corder, Senator John McGee, Senator Dan Schmidt, Representative Sharon Block, Representative Carlos Bilbao, Representative Janice McGeachin, Representative John Rusche and Representative Elaine Smith. Representative Fred Wood was absent and excused. Legislative Services Office staff members present were Ryan Bush, Matt Ellsworth and Toni Hobbs.

Others present at the meeting included Governor Butch Otter, Toni Lawson, Idaho Hospital Association; Rene LeBlanc, Idaho Public Health Districts; Molly Steckel, Idaho Medical Association and Idaho Academy of Physician Assistants; Toni Denney; Bill Roden and Jean DeLuca, Delta Dental; Teri Barker, Moriah Nelson, Jesus Blanco and Tim Heinze, Idaho Primary Care Association; Dan Jones, Idaho Association of Health Underwriters; Zelda Geyer-Sylvia, Jack Myers, Julie Taylor, Woody Richards and Steve Tobiason, Blue Cross of Idaho; Richard Armstrong, Leslie Clement, Paul Leary Christine Hahn, Jane S. Smith and Mitch Scoggins, Department of Health and Welfare; Joie McGarvin, America's Health Insurance Plans; Bill Deal, Shad Priest and Tom Donovan, Department of Insurance; Laren Walker, Idaho High Risk Insurance Pool; Stacy Pearson, Boise State University; Matt Freeman, State Board of Education; Mike Brassey, St. Luke's Regional Medical Center; Tom Shores, Health Underwriters; Sara Stover, Department of Financial Management; Marsha Bracke, Bracke and Associates; Ken McClure; Givens Pursley; Ray Stark, Boise Metro Chamber; Denise Chuckovich, Idaho Primary Care Association; Representative Sue Chew, District 17; Jeff Buel, Johnson and Johnson; Dennis Tanikuni, Idaho Farm Bureau; Trish McDaid-O'Neill, Astra Zeneca; Jeremy Pisca, Risch Pisca; Robin Nettinger, Idaho Education Association; Suzanne Budge, SBS Associates; Winston Inouye, AARP; Pat Sullivan and Amy Holly, Sullivan, Reberger and Eiguren; Corey Surber, St. Alphonsus; John Watts, Veritas Advisors; Kurt Steinbridge, GlaxoSmithKline; Richard Rainey, Tim S. Olson and Scott Kreiling, Regence; Dave Self, PacificSource; LeAnn Simmons, Idaho Voices for Children; Heidi Low, American Cancer Society; Brent Olmstead, Tobacco Free Kids; Lyn Darrington, Gallatin Public Affairs; Steve Thomas, Idaho Association of Health Plans; Skip Smyser; Lincoln Smyser; Amy Johnson, Boise State University; Jayson Ronk, Idaho Association of Commerce and Industry; Robyn Lockett, Legislative Services Office; Brooke Murdoch, Legislative Services Office and Elizabeth Criner, Pfizer.

Senator Cameron introduced **Governor Otter** for opening remarks regarding the Idaho Health Insurance Exchange. **Governor Otter** explained that Idaho must decide by September 30 whether or not to apply for a federal grant to establish the Idaho Health Insurance Exchange. He stated that in 2007 a health care study group was established to start working on an insurance exchange to provide more access to medical care and delivery services. **Governor Otter** noted that a number of things this study group identified were co-opted by the Affordable Care Act. The study group found that many things

Idaho was doing in Medicare and health care services for children and adults were similar to what is in the Affordable Care Act. As a result, the governor is faced with waivers under his executive order. He said Idaho is at a crossroads as to whether to apply for a grant for resources to decide what an Idaho Health Insurance Exchange would look like or whether to let the federal government come in and establish an exchange.

Governor Otter said that recently some things have changed the complexion of Idaho's decision. The 11th District Court of Appeals ruled on the lawsuit of Idaho and 26 other states that individual mandates were unconstitutional. He noted that this is the highest court ruling to date and that the Supreme Court will ultimately make the decision. He said that the court did not address the issue of severability. He also stated that Oklahoma and Kansas have returned grant funds that were left over from their early acceptance of those funds. Kansas said they did not have the time line necessary to make a decision. **Governor Otter** explained that whether or not Kansas will decide to go with a state insurance exchange or allow the federal government to establish an insurance exchange remains to be seen.

Governor Otter stated that the question for Idaho is whether we will have a state insurance exchange that is modeled after and fits the needs of Idaho or whether Idaho will have a national exchange imposed upon it by the federal government. He emphasized that he was not seeking permission to apply for the grant. He was just giving the facts.

Governor Otter explained that he has issued 10 of the 13 waivers requested by the Department of Insurance and Health and Welfare due to the fact that the waivers were for grants Idaho had been receiving before the Affordable Care Act was established. He said the waivers do not add any new programs or new regulatory requirements. With regard to a waiver granted to the Department of Insurance and premium rate review, **Governor Otter** did so because he felt it was better for Idaho to make such decisions instead of the federal government.

In conclusion, **Governor Otter** stated that September 30th is coming quickly and there are still a lot of facts and information to be studied before a decision can be made. He reiterated that if Idaho chooses not to apply for the $40 million grant to establish an Idaho Health Insurance Exchange, the federal government will step in and assume responsibility for the health care exchange within the state of Idaho.

Senator Cameron clarified that if Idaho chooses the federal exchange route, there is no turning back, but if we choose to go with a state exchange, there are off-ramps along the way should we change our mind or if the courts overturn the Affordable Care Act and so on. **Governor Otter** agreed and said that, at any time, if Idaho receives the grant, we can return funds if we get frustrated or overwhelmed; we do not have to return money that has already been spent.

In response to a question from **Representative McGeachin, Governor Otter** explained that the state does not have to apply for a grant to have its own exchange. He said Kansas is an example of this. He noted that there will be a cost for the state to do this on its own. He reminded the task force that Medicaid is intrinsically wound into the Affordable Care Act and choosing not to do what the federal government wants could jeopardize some of the Medicaid funding we already receive.

Director Richard Armstrong, Department of Health and Welfare, and Director Bill Deal, Department of Insurance, were the next speakers. Their complete PowerPoint is available able at the following website: http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Mr. Armstrong gave some background on the impetus of health care reform. He explained that decades of continuous cost escalation threatens health care coverage for citizens. In 2010, 31% of Idahoans 18-34 years old did not have health insurance. Without insurance, access to health care is limited and quality of life is diminished. Current insurance pools for individuals and small businesses insure more people with health problems, resulting in higher claims, premiums and administrative costs, while offering poor value. He stated that the current system is unsustainable, both at the state and federal level.

Mr. Armstrong explained that areas of reform in federal health care take affect at different times. As for federal insurance exchanges, exchanges allow decreased risk for small businesses, market leverage and lower transaction costs.

There are two components of an exchange:
1. Medicaid -- Low income Idaho citizens will use a web-enabled exchange to enroll in a benefit plan.
2. Competitive Market Exchange -- Provides individuals and small businesses easy comparison of price, benefit packages, service and quality.

The Medicaid portion of the exchange is mandated. All states must develop an eligibility interface that will serve all Medicaid applicants. If Idaho chooses to ignore this, we would lose significant funds besides the grant money. He noted that $1.2 billion of our $1.8 Medicaid budget is federal money.

Mr. Armstrong stated that a federal exchange plan is currently being devised. He said that Health and Welfare has tried to get information but the federal government has not provided that. **Mr. Armstrong** expressed fear that a federal program would make Medicaid the primary product.

Mr. Armstrong went on to discuss Idaho's Competitive Marketplace Exchange. He said that Idaho has federal authority to develop a state-controlled exchange. If we do not do that, the default is a federally controlled exchange. Federal planning and implementation for an Idaho exchange requires no matching funds. He emphasized that any exchange developed by Idaho must be certified by January 1, 2013 and operational by January 1, 2014.

Advantages of a state controlled exchange include:
- Allows Idaho to decide which insurance carriers participate to assure more competition and choice.
- The state can encourage citizens to purchase private policies and not enroll in Medicaid.
- The state can maximize premium tax revenue.
- DHW can leverage expensive system upgrades for other programs, such as SNAP.
- This option is less expensive for the state since common architecture reduces expense under Medicaid compliance module.

As **Governor Otter** stated, the deadline to apply for the grant is September 30, 2011. **Mr. Armstrong** explained that if Idaho does not submit an application by this date, the next opportunity is December. Waiting until December would push us into spring and that would make it difficult to meet the January

2013 certification date. He emphasized that this is a massive system and Idaho needs as much time as possible for planning and design.

Mr. Armstrong gave way to **Director Bill Deal, Dept of Insurance,** who explained that Idaho has the lowest group rates in the nation and is among the lowest for individual rates. With regard to the waiver that **Governor Otter** mentioned, **Mr. Deal** said that the Department of Insurance was surprised when Health and Human Services (HHS) told them that Idaho did not comply. He said that the Department had been told by an actuary that our rates did comply. The Department of Insurance did receive the waiver and hoped to be able to maintain the practice of state-based rates, not federal. He noted that this waiver did not cost the state any money.

Mr. Deal went on to say that during the 2011 Legislature, questions arose regarding rates. HHS has proposed rules for implementation of health exchanges. These were released in July. HHS issued proposed rules for Medicaid eligibility changes in August and the Department of the Treasury issued proposed rules on premium tax credits in August. If an Idaho exchange is not certified by January 2013, the federal exchange will be put in place and operational by January 2014.

Mr. Deal showed a chart of states relating to the process of legislation on insurance exchanges. Idaho is one of 12 states that has not introduced any legislation. If Idaho applies for the grant on September 30, we will apply for $26 million, but the total of the grant is $40 million. He explained that money is reimbursed as it is spent.

Mr. Deal said that planning is going well and is focused on stakeholder input, background research, program integration with Medicaid and CHIP, IT systems and the project plan. His PowerPoint presentation shows more detailed charts of other states' cost estimates, Idaho's insurance coverage of non-elderly and a time line of Idaho's exchange versus the federally controlled exchange. This is available at: http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Mr. Deal said that the bottom line is if by January 1, 2013, Idaho does not demonstrate that it will be ready to run a certified exchange by January 1, 2014, the federal government will impose and run an insurance exchange in the state. In his opinion, a federal based exchange in Idaho would be very disruptive. He said this would mean that health insurance would no longer be state-based.

Mr. Deal made the following proposal:

1. Apply for federal funding for an Idaho Exchange.
   - Submitting grant application does not lock Idaho into building a Competitive Market Exchange.
   - Securing a grant allows Idaho time to make decisions.
2. Wait for lawmakers to decide options for an Idaho Exchange.
3. Return/Accept funding for an Idaho Exchange based on state decisions.
4. By not meeting grant application deadline, Idaho forfeits the opportunity to decide on its exchange.

Senator Stegner asked whether Idaho can meet the January 2013 deadline if we go ahead and apply for the grant by September 30. **Mr. Deal** said that he has confidence that we can do this. He said that if we follow the steps on the time line without any hiccups, we should be able to meet this. In his opinion, this

could get done in one year. **Mr. Armstrong** added that the federal government realizes the tight time frame and that there has been a bulletin issued addressing the possibility of flexibility of the deadline.

Representative Rusche asked, in a federal exchange, whether premiums would be determined by the federal government or the state pool. **Mr. Deal** said his understanding was that if the federal government created the exchange, the ratemaking process would be taken away from state-based regulation. He added that this is a major concern both with the federal exchange and with Medicaid. **Mr. Armstrong** agreed and said that the structure of the benefit plan would be controlled by a federal entity. He added that Medicaid could be favorably priced in a federal exchange but that would be burdensome to Idaho.

Senator Cameron commented that Idaho has low premiums because we do not have a lot of mandates and asked whether it would be safe to assume that fewer carriers, fewer products and more mandates would mean higher rates. **Mr. Deal** agreed and said he thinks plans would be similar for all states in a federal exchange.

In response to a question from **Representative Rusche, Mr. Deal** agreed that the protections in statute for providers would no longer apply with a federal exchange. He said the Department of Insurance receives many complaints every month, and if the federal government was in charge, people would not be able to deal with the state when they need help. He added that there are a lot of unknowns.

Representative Rusche asked what will happen to premium tax being collected. **Mr. Deal** said that was unknown at this time. If the plans are not provided by domestic carriers, they are not sure if they can collect premium tax from national insurance carriers. He mentioned that the costs of the federal program could be covered by a premium tax.

Senator Goedde commented that Kansas is looking at doing its own exchange without a federal grant and asked how much it would cost for Idaho to develop an exchange without the federal money. **Mr. Deal** said the state would have to follow the format of HHS for health care reform so the cost would be similar to the $40 million grant amount. If we do not have to follow all of the requirements, it would be less. If the state develops an exchange that can be certified, the cost would be close to $40 million.

Senator Goedde said he has heard of some groups taking large increases in premiums because companies are afraid they will not able to raise rates after this takes place. **Mr. Deal** said that was true in some states such as Massachusetts, due to the increased number of people their plan covered.

Senator Cameron asked about initial setup costs. **Mr. Armstrong** said that compliance for Medicaid (which is required) is estimated to be about $30 million. He said they do not know the exact costs because not enough information has been released. He thinks it might even be more expensive to interface with the federal system. He added that the beauty of an Idaho exchange is that we control both sides. This is much easier to handle.

Senator Cameron asked about the potential for Medicaid enrollment increases and whether there would be a difference between a federal exchange and an Idaho qualified exchange. **Mr. Armstrong** said that a federal exchange would try to reach out to those who might be eligible and this could bring out people that are currently qualified but do not participate. He said that as many as 100,000 more could join Medicaid if the federal government does reach out.

In response to another question from **Senator Cameron** regarding potential loss of revenue, **Mr. Armstrong** said that Idaho has one of the highest FMAP rates. If Idaho is out of compliance, we could get a worse rate and lose even more money. **Mr. Deal** stated that if a federal exchange were imposed, Idaho companies could lose market share which decreases premium tax. He said a federal exchange would also mean fewer agents.

Representative McGeachin commented that according to one of the slides, HHS has proposed rules for implementation of health exchanges. She asked whether there has been anything released about Medicaid that would give clues as to the federal requirements from HHS in these rules and whether Idaho can comply with the rules currently. **Mr. Armstrong** explained that the federal rules apply universally to all exchanges and are published with the idea that the rules apply whether you are building a state exchange or a federal exchange. He commented that the idea of a federal exchange happened because all states were supposed to have an exchange and some were not doing so. **Mr. Armstrong** said they know what the rules are to build a federally certified state exchange but the rules do not specify programming language, structure or mechanics; that is left up to Idaho. With a federal exchange, Idaho does not know what their requirements are that will allow our program to interface with theirs.

Mr. Laren Walker, High Risk Reinsurance Pool Administrator, was introduced to give an update on the High Risk Insurance Pool. His complete PowerPoint is available at:
http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Mr. Walker explained that the High Risk Reinsurance Pool was created in 2000 in an effort to bring about a more competitive market and to make health insurance coverage available to Idaho residents not covered by employment-related insurance. The pool receives funding from reinsurance premiums paid by carriers based on mandatory ceding of risks. Funding is also provided by a portion of the state's premium tax revenue. In addition to this funding, the High Risk Reinsurance Pool has received about $4.3 million in federal grant money. He noted that this $4.3 million in grant funds does not include 2011 money in the amount of about $1.25 million. He also stated that the pool can assess costs to carriers, if necessary, but there has never been an assessment of carriers since the pool was created.

Mr. Walker's PowerPoint includes charts showing funding history from 2000 to the present. He noted that the 2011 amounts are only partial year amounts.

Mr. Walker explained that the High Risk Reinsurance Pool has five plans with different deductibles, co-insurance, out-of-pocket expense and lifetime maximum. All plans except the HSA Compatible have a $5,000 deductible for normal maternity. Most of the enrollment is in Cat B and the HSA Compatible Plans. His presentation contains more information regarding the benefits of each plan.

Representative Rusche asked what will happen to the benefit package under the insurance exchanges. **Mr. Walker** stated that if we have an Idaho exchange, these products would still be offered, but that is doubtful under a federal exchange.

Mr. Walker said that the HSA product was introduced in 2007 and has grown a lot since that time. All other products remain pretty flat. **Senator Schmidt** asked whether this enrollment pattern was a

preference or marketing. **Mr. Walker** explained that they do not market the plans directly. He thinks it is just a market preference.

In response to a question from **Representative Block, Senator Cameron** clarified that if a federal exchange exists, it will likely reduce premium tax and hurt the High Risk Reinsurance Pool.

Senator Stegner asked about children in the pool. He asked who is eligible and how are they eligible. **Mr. Walker** said that as the administrator, they do not see the behind the scenes; the carriers see that. **Senator Cameron** noted that it could be a child whose parents, due to income, do not qualify for CHIPS or Medicaid, so they end up in the High Risk Reinsurance Pool. Most of these children are very sick.

Mr. Jack Myers, Chief Financial Officer, Blue Cross of Idaho, agreed to move up on the agenda as the next speaker. His complete PowerPoint is available at:
http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Mr. Myers presentation involved the response of Blue Cross to health care reform, including the impact on product, rates and policies.

Mr. Myers stated that effective Sept 23, 2010, per federal health care reform:

- Dependent children covered up to age 26 (BCI early adoption in June for individual, upon renewal for groups)
- There will be no pre-existing waiting period for those over age 19
- Preventive health services with no cost sharing
- Replace $1 million lifetime max with annual limits and no annual limits in 2014
- No dollar limits on “essential” benefits
- 54% of our employer groups elected grandfather status
- Revised contracts filed with DOI and approved prior to October 1

Mr. Myers explained that the price impact of the Sept 23, 2010 changes were roughly 1% of the benefit rates. **Representative Rusche** asked whether this included mental health parity and **Mr. Myers** said that was correct.

Mr. Myers discussed how the medical loss ratio is calculated and said it is currently about 80%, which is in compliance.

Regarding rate review, **Mr. Myers** said that Blue cross is in favor of a state run health exchange. He said the Department of Insurance is seeking approval to be the primary rate reviewer and they are modifying their website to receive public comments. He noted that insurance companies will be required to waive confidentiality to allow state review of rates.

Senator Corder asked why insurance companies would be spending 1% or any amount in order to improve health care quality. He would assume that should be spent by providers of care. **Mr. Myers** agreed that the majority of this is the responsibility of the provider. For insurance companies, this spending is to help improve coordination between providers and the like. They also provide disease prevention programs.

Senator Cameron commented that the formula is dictated by the Affordable Care Act.

Senator Corder asked what would be the dollar figure of this 1%. **Mr. Myers** said that would depend on the individuals being insured and is figured per their premium.

In response to another question from **Senator Corder** regarding the maximum lifetime benefits change, **Mr. Myers** said that amount is based on Blue Cross data from their actuary. They looked at the incidence of claims occurring over $1 million, how often and so on. Everything is an estimate and said that number will increase as we move toward 2014 and the maximum goes away completely. **Senator Corder** said it would be interesting to monitor this for a number of years to see what really happens. **Senator Goedde** asked whether there was anything in the Affordable Care Act that would restrict rate increases. **Mr. Myers** said that competition has a lot to do with rate increases. He noted that any rates filed after September 1, 2011greater than 10% must have public disclosure. **Senator Schmidt** asked whether Blue Cross had any rate increases that high. **Mr. Myers** said "yes" but they try to focus on stability in rates as much as possible. He noted they have to file information showing why the rate increases are higher than 10%.

Senator Cameron commented on **Mr. Myers'** PowerPoint slide which stated that 54% of employers elected grandfather status. **Senator Cameron** added that initially it was his understanding that individuals were allowed to do this, but that option was eliminated. **Senator Cameron** asked for more information on that. **Mr. Myers** said he would have to get that information at a later date as he was not aware of individuals being allowed this option.

Mr. Myers went on to discuss insurance changes for 2014. These changes include:

- Guaranteed Issue / Mandate
- Initial Open Enrollment: October - February
- Adjusted Community Rating
- Fees on Insured Policies of $8B to $14B
  - Will cost BCI members $29M in 2014
- Standard Metallic Benefits from 60% to 90% actuarial value
- Reinsurance, Risk Corridors, Risk Adjustment

He commented that allowing everyone into the program increases the risk of someone getting insurance only when they are really sick.

Mr. Myers said that the U.S health care spending is $2.7 trillion today or $8,650 per person. This will grow to $4.6 trillion or $13,710 by 2020. He said that the current fee to service reimbursement rewards over-utilization. Health care reform provides for cost control pilots, but they are not scoring any real savings. He commented that wellness programs should be put in place to address that high cost of personal lifestyle choices.

Mr. Myers went on to discuss Medicaid as follows:

- MACPAC June 2011 Report to Congress
  - Comprehensive Risk Based Medicaid enrollment grew from 38% in 2000 to 48% in 2009
  - Primary Care Case Management remained at 14%
- 225,000 current Idaho Medicaid beneficiaries
- 100,000+ expansion through HCR

- Lewin estimates Managed Medicaid savings of $37 million in year 1 and $99 million in year 9
- Significant eligibility shift expected between exchange- subsidized insurance and Medicaid
- DHW to conduct a study of Medicaid managed care opportunities by November 1 and report recommendations to JFAC during the 2012 Session
- Probable dual eligible demonstration project for 2013

Senator Schmidt asked about options available besides fee to service reimbursements. **Mr. Myers** said there are a variety of cost control measures in place. He said the most significant factor affecting premium rates is benefit design. Being a lower income state, most people tend to have higher deductibles and lower rates.

Senator Stegner asked for clarification of a Blue Cross comment stating that coordination of care across services produces that greatest savings. He asked whether that comment includes behavioral health care. **Mr. Myers** said "yes, integration achieves greater savings."

Before the task force recessed for lunch, the January 6, 2011 minutes were approved unanimously by voice vote.

After lunch **Ms. Stacy Pearson, Vice President of Finance, Boise State University,** was introduced to give a summary of the Higher Education Insurance Feasibility Study. Her complete PowerPoint is available at: http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm. She introduced **Sarah Jones, Director of Compensation and Benefits, Boise State University; Amy Johnson, Associate Director for Government Relations, Boise State University; Matt Freeman, State Board of Education; and Teresa Luna, Director, Department of Administration.**

Ms. Pearson said that there are eight colleges and universities on the state insurance plan. This makes up about 26% of employees on the state plan. She explained that in 2009 and 2010 changes were made to the state group insurance program that presented significant challenges to the higher education institutions' ability to attract and retain quality faculty and staff. Specific examples include:

- Implementation of ***part-time insurance premium tiers***, which resulted in making coverage unaffordable to many employees, and adding significant administrative burdens to track, report and reconcile enrollment and contribution records.
- Creation of a ***90-day waiting period for insurance coverage***, resulting in a program that is not competitive for higher education, and creating additional costs for the university when COBRA insurance premiums were reimbursed during the first three or four months.

In the fall of 2009 the university presidents met with the Governor to discuss some of the challenges facing higher education related to health care and benefits. The Governor agreed to allow the institutions to conduct a feasibility study for the purpose of determining the fiscal viability of developing and administering a separate insurance program for higher education.

In 2010, after an RFP process, the four 4-year institutions and the four community colleges engaged Aon/Hewitt, a global HR consulting firm with extensive expertise in higher education insurance, to conduct the feasibility study. From March to July 2011, Aon/Hewitt delivered and presented study results to the Higher Education Insurance Consortium. Boise State and board staff presented study

results to the Legislative Services Office, Department of Administration, President's Council, Lieutenant Governor and State Board of Education

Ms. Pearson said that the institutions want more control and flexibility in vendor selection, eligibility, plan design, funding and strategic management of insurance programs. They want the opportunity to enhance the value of benefits delivered to faculty and staff, as well as a program that is more responsive to the needs of higher education.

Ms. Pearson stated that potential savings were identified to higher education in the range of $2.2 - $6.7 million, derived from provider discounts, cost management, plan design and pharmacy benefit changes.

Ms. Pearson stated that the study brought forth two key questions:

1. Can these improvements be met within the current Department of Administration Group Insurance structure?
2. Could all State agencies and employees benefit from these proposed improvements?

Key interests include:

- **A Seat at the Table**: input and involvement in the planning and decision-making of our insurance program; a voice to articulate our needs;
- **Transparency**: information sharing for our plan utilization, cost drivers, and renewal options; opportunities to target communications to influence employee behaviors;
- **Vendor Collaboration**: leverage existing insurance provider programs to help control costs and improve employee satisfaction. Establish vendor relationships, leverage technology to reduce errors, and improve efficiency;
- **Flexibility and Control**: early involvement and input in the renewal planning, communications, and open enrollment timing to better meet the needs of faculty work schedules.

Ms Pearson went on to discuss examples of desired changes including the ability to offer new or different benefit options, such as improved vision insurance benefits or additional amounts of supplemental life insurance with the premium paid by the employee. They would also like to be able to carve out certain benefits such as pharmacy benefits to take advantage of collective purchasing opportunities and innovative, more cost-effective plan designs. Her complete PowerPoint goes into more detail regarding changes they would like to see.

Ms. Pearson said that in a meeting with the Department of Administration they discussed prospective changes in the provisions and management of insurance programs with the state Office of Group Insurance. This would be a collaborative approach to identify the best and most efficient practices that could greatly improve the benefit package for all state employees, particularly after multiple years with no compensation increases.

Ms. Pearson stated that with these changes, there is a potential savings in excess of $2 million just for higher education and, if extended to all state employees, that savings could be as great as $7 to $8 million.

During the meeting there was also discussion of further development of wellness programs and preventative medicine programs. There was a suggestion of rebidding some of the current programs (i.e., life insurance and long-term disability) to ensure the best deal. One very important suggestion was that higher education be allowed to participate in the Insurance Advisory Council to the Office of Group Insurance to actively participate in plan design, bidding process and program evaluation. She said this would require a statutory change.

One large issue for higher education is the part-time health insurance tiers. **Ms. Pearson** said that they would like to pursue a change from the three tiered part-time employee health insurance to two tiers in which employees working greater than 30 hours (or so) receive full-time benefits at the state employee premium rates. Employees working 20 to 30 hours pay a higher portion of health insurance premium but still have access to state health insurance and employees working less than 20 hours continue to be non-benefit eligible.

She explained that this change alone will be a significant improvement and would reduce the need for part-time employees to move between tiers during the benefit year. It accommodates 9 and 10 month staff appointments, potentially providing more affordable coverage. Some staff is forced to move between the various tiers during the year, resulting in having to pay higher premiums for 3 - 6 months, regardless of regular work schedules. This is administratively cumbersome, inefficient and difficult to communicate to employees and managers.

They would also like to eliminate the ten-month waiting period for the flex spending account and eliminate the administrative fee. She said that costs associated with administration and for the few instances in which employees might take the full flex spending benefit and then leave state employment prior to making their full contribution could be covered by the flex spend amounts that are left in the program by employees who do not utilize or claim the full benefit. According to **Ms. Pearson,** this is consistent with how most private business and government organizations manage this benefit, and it should not cost the state any additional money.

Ms. Pearson went on to say that immediate next steps should include:

- Follow up with Department of Administration on time lines and action items;
- Pursue higher education participation of the Group Insurance Advisory Council in the state Group Insurance Program;
- Assist in redesign and analysis to modify the part-time insurance premium structure;
- Working on immediate changes in Flexible Spending Account benefit to eliminate waiting periods and employee paid administrative fees;
- Research legislation that may need to be revised/updated to accommodate these and other desired changes.

Future actions will include:

- Work with executive and legislative authorities to implement the needed changes;
- Provide support and feedback, monitor progress to ensure that solutions are being implemented;
- Encourage best practices and focus on wellness programs similar to NIC and UI programs;
- Reassess to determine if higher education needs are being met or if other options should be pursued;
- Encourage that savings are reinvested to improve benefits, reduce costs, and provide funding for salary increases.

In response to a question from **Senator Goedde** regarding claims experience, **Ms. Pearson** said that the claims experience for higher education was given to the consultant.

Senator Goedde asked, regarding a comment that higher education employees had healthier lifestyles and better claims experience, whether they feel that higher education employees are offsetting the costs of other less healthy populations. **Ms. Pearson** said that studies in other states have shown that higher education tends to have healthier populations, but that is not apparent in Idaho.

Representative Block asked about the possibility of extending the higher education benefits to all state employees. **Ms. Pearson** said they did not discuss this with other state agencies, but the study led them to believe that the entire benefit package could be used to benefit all state employees. When the Office of Group Insurance looks at plan design, she is sure that other agencies would like to be part of the discussion.

Senator Schmidt asked if people that are self- insured were included in the study. **Ms. Pearson** said they did discuss both successes and challenges of the self-insured. Many programs they have could be adopted on a larger scale.

Senator Cameron asked how potential savings of $2.2 to $6 million derived from provider discounts, cost management, plan design and pharmacy benefit changes could actually happen. **Ms. Pearson** said that the study looked at current benefits the university received and found they seemed to have better design. This led them to ask when the last time was that state insurance looked at this. The dollar figure was taken from a number of university employees on the state system. She said there is a more detailed report available; **Senator Cameron** said he would like that. **Ms. Jones** explained that a lot of the savings and opportunities to increase satisfaction and the scope of benefits had to do with updating the program and gaining access to discounts through competitive bidding (life and disability insurance). Montana has developed its own pharmacy benefit program that is self-funded and has saved a lot of money. The Montana pharmacy program is expanding to allow other states or entities to participate. Larger volume does allow cheaper costs. They also looked at employee paid benefits. **Senator Cameron** commented that a lot of this savings seems surmised rather than hard data and he thinks the state has done a good job with provider discounts. He added that a move to pharmacy benefits reduces costs but that usually means limiting where people can get pharmaceuticals or what drugs are allowed. He continued that the goals of university faculty might not always be same as the entire state employee population and asked whether university plans were better than state plans or about the same. **Ms. Jones** said they did present a number of benchmarks specific to benefit features and, in many instances, it showed state benefits were not competitive to benchmarks. **Ms. Amy Johnson** said the largest savings areas were the rebidding life and disability benefits. She said there are some things in the benefit plan that might not need to be included.

Senator Stegner said he was sympathetic to the difficulty universities face in trying to fit into the entire insurance plan for all state employees. He would like to see what could be done to satisfy some of the dissatisfaction they have in terms of the challenges to administering the plan to their employees. He would like to see if there was a way to change the waiting periods and the tiers. **Senator Stegner** said he was not as concerned with cost savings and said if there could be an improved working situation for higher education, which would be a benefit in itself. He asked whether they plan to ask the Legislature

for a specific exemption from participation. **Ms. Pearson** explained that when they started the study they thought maybe higher education wanted too many things that state insurance was not interested in providing. As the discussion continued, they found that many of the benefits they wanted were common in other states. She said it will be costly for higher education to separate from the state insurance. When they saw the nature of improvements that could be made, they thought it would be worthwhile to start to work with the state because many of these changes could benefit all state employees. She added that they would want to review this in a year. **Senator Stegner** asked whether they feel they are getting the cooperation necessary to move forward. He added that the suggestions make a lot of sense to him. **Ms. Pearson** said they were getting the cooperation necessary.

Ms. Luna said she is happy with the progress that has been made in working with higher education. They have been asking for these changes for a long time. She said the Office of Group Insurance has taken a fresh look at what they have asked for and thinks they could take care of some of the requests quickly. These changes include:

1. Having a seat at the OGI advisory council for higher education ;
2. Changes in the part-time tiers for insurance and looking at changing to a two tier policy;
3. Eliminating or reducing the ten month waiting period for the flex spending account. **Ms. Luna** said she does not see why there is a waiting period at all and that it will likely be changed in July to a three-month waiting period at most.

Ms. Luna commented that is very important to look at the suggestions to keep higher education on board and part of the state employee insurance. She noted that the universities have been very reasonable.

Senator Cameron asked for more information regarding the rebidding for disability and life insurance, enhanced vision benefits and a survey of all employees on their benefits. **Ms. Luna** said they have not discussed a survey of all state employees to see what they want and that this would be a resource issue. Presentations regarding the rebidding life/disability insurance are occurring at this time. It has been over five years since it was last bid. As for the enhanced vision, they are going to look into that, and they could probably add a better benefit at a small cost to the employees.

Senator Stegner said that vendor collaboration and utilization reports do not seem like they would be a problem. **Ms. Luna** said it is not as much of a vendor issue as it is the Office of Group Insurance wanting to make sure the information that is delivered to state employees is the same. This has to do with thinking outside the box. She said it makes sense for larger agencies to have utilization reports to see what is happening within their populations.

Senator Goedde asked for clarification of the ninety-day waiting period being eliminated. **Ms. Luna** said it has been eliminated in the Department of Administration's intent language. **Senator Cameron** explained that this year's appropriation did not require a waiting period, so it falls back to the Department of Administration.

Representative Rusche asked, since the University of Idaho has its own health insurance program, was there any discussion of including them back into the state plan. **Ms. Luna** said "not at this time." They just want to make sure those employees in the state plan stay in the state plan. She added that she is not sure the University of Idaho would be interested because they have a very good plan with low costs.

She noted that College of Southern Idaho is in its second year of not being on the state plan. **Mr. Freeman** stated that neither the University of Idaho nor North Idaho College is interested in coming onto the state plan. North Idaho College has not been on the state plan for many years. He noted that the College of Southern Idaho is open to coming back to the state plan and that it was the ninety-day waiting period and the tiers they had problems with.

Senator Goedde said he would also like a copy of the more detailed report and asked how long the consultant was used to compile the report and the cost. **Ms. Pearson** said the cost was $60,000 and it took from November through March to complete.

Senator Cameron reiterated that he would like to see the full report and that the task force looks forward to helping where they can.

Dr. Christine Hahn, Idaho Immunization Board, Department of Health and Welfare, and Dr. Richard Rainey, Chairperson of the Idaho Immunization Assessment Board, were introduced and gave updates on the Idaho Immunization Program and the Immunization Assessments. **Dr. Hahn** stated that 2010 was a busy year for the Idaho Immunization Program and her PowerPoint presentation contains an overview of the program components and updates on the major programmatic events of the year. The complete PowerPoint is available at:
http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Dr. Hahn noted that there has been rise in pertussis (whooping cough) and that California had nine infant deaths from this last year. The goal here is to vaccinate adults and older children since that is how babies are infected with whooping cough.

Dr. Hahn went on to discuss legislation that was passed in the 2010 Legislative Session. During the 2010 Legislative Session, Idaho's Immunization Reminder Information System (IRIS) was changed from an opt-in program to an opt-out program. This system keeps track of people's vaccinations and provides a more robust resource for citizens, parents, schools, daycares and health care providers needing access to these records. She noted that more adults have opted-in to IRIS since the H1N1 vaccine.

Dr. Hahn explained that House Bill 495 created the Childhood Immunization Policy Commission. This commission is chaired by Dr. Tom Rand and meets quarterly. The purpose is to evaluate policies regarding childhood immunization in Idaho and make recommendations to the Board of Health and Welfare on policy and to the Idaho Legislature on legislative action to increase immunization rates. This Commission provided advice and input into rule and statute changes during the 2011 Session. Some of those rule changes include updated immunization requirements for school children and those in licensed daycare. Other changes brought preschool children back into the rules and included new requirements for children born after September 1, 2005. Statute changes include allowing electronic immunization records as proof of immunization and allowing for other licensed medical personnel to sign immunization records (not just physicians). **Dr. Hahn** emphasized that none of these changes eliminate parents' rights to exempt their children from any or all vaccines.

Dr. Hahn noted that immunization assessment changes are now tied to the Advisory Committee on Immunization Practices (ACIP) recommendations. House Bills 432 and 657 created a system of

assessments on insurance carriers to maintain vaccine access to all Idaho children. The Vaccine Assessment Board was created to govern the assessment process. **Dr. Hahn** introduced **Dr. Richard Rainey** to provide an update on the Assessment Board.

Dr. Rainey explained that the first assessment in 2010 of $47 per program-eligible child successfully collected $10.1 million to fund vaccines for children with insurance coverage of vaccines during fiscal year 2010-2011.

The Assessment Board determined the 2011 assessment to be $58.18 per program-eligible child based on survey responses indicating 201,000 children with insurance coverage of vaccines. The board considered the numbers and costs of vaccines and a $1.9 million carryover surplus from 2010-11. The 24% increase was primarily due to an additional covered vaccine (the human papillomavirus vaccine) (HPV) and also due to increased vaccine costs. All vaccines recommended by ACIP are now funded by the assessment.

Dr. Rainey said it is estimated that the 2011 assessment will collect a total of $11.7 million. To date $6.7 million has been collected. **Dr. Rainey** explained that Tricare (the health care program serving active duty service members, National Guard and Reserve members, retirees, families and survivors worldwide) is the only large carrier that is not paying assessments. Other than Tricare and three other carriers, all surveyed carriers are current in their 2011 assessment payments.

Dr. Rainey said that the board is operating in a manner consistent with the amendments made earlier this year to include:

- Contracting for administrative services permitted
- Consultations permitted
- Coverage of ACIP-recommended vaccines

He said that the board will meet next month to review its plan of operation to incorporate these amendments. The board also plans to fine tune its schedule of calculating the assessment amount and to elect new officers.

Dr. Rainey stated that the board is mindful of its July 2013 sunset date and appreciates the task force's interest. He said they do plan to mention the sunset date in future reports to the task force and to legislators prior to the 2013 Session.

Both **Dr. Hahn's** PowerPoint and **Dr. Rainey's** comments are available at:
http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Senator Stegner asked about the vaccine for shingles. He commented that he understands this is more for adults but wondered whether they were effective and becoming a standard. **Dr. Hahn** said, in her opinion, the vaccine is great and effective. She noted that it is focused on those over 60 years of age and that currently her Department focuses only on children, so she does not have much information.

Senator Cameron commented that prior to 2010 the state had lost federal grant money because immunization rates had dropped and asked whether those rates had increased. **Dr. Hahn** stated that as immunization rates go up, federal funding should also go up.

Mr. Scott Kreiling, President, Regence Blue Shield, was the next speaker. His complete PowerPoint is available at: http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Mr. Krieling said that in looking at health insurance reform for insurance companies and a complexity standpoint, a lot of the rules are not written yet. He noted that they are going to work closely with the Department of Insurance to make sure they are able to comply with those rules. He said that, in his opinion, the insurance companies are working collaboratively to make sure they will be able to meet the state exchange time line.

Mr. Krieling went on to discuss reform assumptions as follows:

- 2010
  - Preventive Coverage with no cost-sharing
- 2011
  - Medical Loss Ratio Limitations
    - 80% Small Group / Individual, 85% Large Group
- 2014
  - Rating Limitations (Age Bands, Gender, Health Status)
  - Guaranteed Issue for Individual
  - No pre-existing conditions limitations
  - Medicaid Expansion

He noted, in response to **Senator Goedde's** question regarding whether insurance companies are trying to raise rates now because of perceived changes in the future, that Idaho has a very competitive landscape between carriers, so they are not trying to increase rates. He added that Regence decided to send their rate-setting information for both small group and individuals to an independent third party to make sure they are fair.

Mr. Kreiling stated that reform is an access issue and it will add more people into a system that is broken. According to **Mr. Kreiling,** health care reform versus access reform addresses access and increased benefits; adds increased regulation with age band compression, guarantees issue and no pre-existing conditions; and adds the ineffective mandate of the healthy uninsured staying uninsured. He added that there are numerous regulatory decisions still to come and costs continue to rise.

Mr. Kreiling reiterated that so much is unknown regarding a federal exchange that it is hard to say how that would affect Regence. He did say that an Idaho exchange would help Idaho citizens in many ways.

In closing **Mr. Kreiling** said that they are looking ahead at infrastructure needs for health insurance exchanges, state and industry capacity to comply with new insurance regulations, financial and market impact of insurance regulations, as well as information and outreach to consumers.

Representative Rusche asked whether Regence or Blue Cross would participate in a federal exchange and, if not, what would that mean for the companies. **Mr. Kreiling** said he could not answer that at this point because they do not know all of the rules regarding the federal plan. In his opinion, Idaho would lose a lot by not developing a state exchange.

Mr. Myers, Blue Cross, said they also strongly advocate a state exchange. He noted a compelling factor is that individual and small groups would not be eligible for subsidies as the current federal plan exists. He added that hundreds of thousands of Blue Cross members could not afford coverage without subsidies.

Mr. Paul Leary, Deputy Administrator, Division of Medicaid, Department of Health and Welfare, gave an update on CHIP B and the Access Card. His complete PowerPoint is available at: http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Mr. Leary said that the number of children eligible for premium assistance/direct coverage through Title XXI decreased from 25,523 in 2010 to 24,818 in 2011. These are traditionally children that are at 150% and 185% of the federal poverty level.

For the Preventative Health Assistance Program (PHA), the number of children required to pay a premium as of June 2011 was 12,345. This program subsidizes premiums if parents keep their children's wellness visits and vaccinations up to date. Approximately 70% of these children have earned enough PHA wellness points to offset the amount of premiums owned. He noted that premium billings and application of PHA offsets have been incorporated into the Medicaid Management Information System (MMIS).

On the marketing side, **Mr. Leary** commented on the following activities:

- Marketed to reach uninsured who currently qualify for programs
  - Updated brochure for all children's programs distributed to all Idaho school districts, health departments, primary care providers, and other stakeholders
  - Child-only application for health care used in outreach conducted by CHIPRA Outreach Grantee (Mtn States Group) and other community partners
  - Working with CHIPRA Outreach grantee (Mtn States Group) in assessing impact of various targeted outreach strategies
    - PSAs released this month (August)
    - Grant funding ends in September- 2nd round of CHIPRA grants pending
- Completed renewal process for HIFA 1115 Waiver (Access Card programs)
  - Developed program evaluation plan, currently waiting for CMS approval

Future activities include supporting community partners in developing strategies to reach children who are eligible but not enrolled and developing a transition plan for 2014.

Mr. Leary's presentation also includes a premium tax fund projection balance sheet for state fiscal years 2005 through 2012. This is available at:
http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Senator Schmidt asked how the CHIP program would be affected by the Affordable Care Act. **Mr. Leary** said they do not know for sure at this time. He stated that they have maintenance of effort through 2019 but only have funding through 2015, and it is not likely that funding will continue if programs in the Affordable Care Act go forward. In 2013 or 2014 CHIP funding for Idaho would be 100% thru 2015.

Mr. Leary and Leslie Clement, Deputy Director Medicaid, Behavioral Health and Managed Care Services continued with an update for HB260. This is the first update so **Mr. Leary** focused on implementation. This is also available at:
http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

The first area of focus was the change in pharmacy reimbursement. This moved from average retail price minus 12% to average acquisition costs. **Mr. Leary** stated that the generic implementation was completed on July 5, 2011. The single source drugs reimbursement change to average actual acquisition cost (AAC) is October 1, 2011. This also will use a tiered dispensing fee. He said it is very important to implement the single source drugs change and the tier dispensing fee at the same time. The projected general fund savings is $2 million.

Mr. Leary went on to say that HB260 reduces adult psychosocial rehabilitation (PSR) services to four hours per week. This was implemented on July 1, 2011 with a projected savings of $2.27 million. This also includes a management tool for PSR services with quality assurance work being performed by mental health care management staff and includes utilization of the LOCUS/CALOCUS assessment tool to further enhance the overall management of PSR service usage. He said they will be focusing this on high users or long-time users of PSR services first and then move to the low users. Subsequent reports will focus on appropriate and inappropriate service usage.

His complete report goes into more detail regarding implementation of HB260. This is available at:
http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Representative Rusche commented that it seems that there will be extensive system changes required for the new copayment requirement. He asked whether Idaho has spent more money changing the system than the savings that will be realized. **Mr. Leary** admitted that the system change will cost money but will be worth it in the long run.

Senator Cameron asked about the expiration of the hospital and nursing home assessments and whether or not that would be extended. **Ms. Clement** commented that they are meeting this week to look at the forecast for 2012. She said they are monitoring this carefully. She noted that hospitals are not interested in extending the sunset and there is no Department of Health and Welfare legislation being prepared at this time.

Ms. Clement continued with a discussion of Idaho Code section 56-261 – Medicaid Cost Containment and Health Care Improvement Act. This was also part of the HB260 update and is contained in the same PowerPoint discussed above. It is available at:
http://www.legislature.idaho.gov/sessioninfo/2011/interim/health care.htm

Section 56-261:

- Identifies the current health care delivery system of payment to Medicaid health care providers on a fee-for-service basis which fails to provide the appropriate incentives and
- Can be improved by incorporating managed care tools, including capitation and selective contracting, with the objective of moving toward an accountable care system that results in improved health outcomes.

Section 56-263 – Medicaid Managed Care Plan:

- Directs the Department to present to next year's Legislature a plan for Medicaid managed care with focus on high-cost populations
- Requires that the plan include certain elements:
  - Improved care coordination through medical homes
  - Improved coordination & case management of high-risk, high-cost adults
  - Managed care for behavioral health benefits
  - Elimination of practices that result in unnecessary utilization and costs
  - Contracts based on gain sharing, risk-sharing or a capitated basis

House Bill 341, Section 24 of the Department of Health and Welfare's appropriations bill directs Medicaid to:

- Complete an actuarial analysis of all Medicaid plans by population, subgroup and region before November 1, 2011
- Provide a copy of the actuarial report to DFM and LSO by December 1, 2011 and
- Provide the report with recommendations for the next phases for implementation of managed care to JFAC during the 2012 Session.

Ms. Clement also discussed activities as of August 2011 for Managed Care in detail. These activities are covered in her PowerPoint presentation.

Next steps for managed care include scheduling a public forum and inviting health care delivery system stakeholders for a panel discussion to obtain advice on how best to implement managed care in Idaho by October or November 2011, monitoring other state Medicaid care initiatives and participating in upcoming national dialogue with other state Medicaid directors on the next phases of managed care and accountable care organizations. They also plan to invite other state Medicaid managed care experts to Idaho to share best practices and lessons learned.

Ms. Clement commented that a report will be delivered according to legislative requirements and will include actuarial analysis results, a summary of 2012 activities regarding development, and recommendations.

Representative McGeachin commented that several of the proposed changes in HB260 were dependent on CMS approval and asked for an update. **Ms. Clement** said they are monitoring that and that it is not unlike any other type of waiver amendment. She said there is always give and take and that she thinks CMS will approve the waiver amendment. In response to another question from **Representative McGeachin, Ms. Clement** explained that the state plans to make amendments using some of the slides from **Mr. Leary's** presentation and that they do not anticipate any problems with those being approved. She said there is a ninety-day time frame, but the clock can be stopped to ask questions, so it can take longer. She noted that there has only been one waiver amendment that was denied in her time with the state and they expect all amendments to be approved.

Senator Cameron thanked all of the presenters. He noted that the issue of health insurance exchanges is very important and he would like to retain that for the entire task force instead of forming a subcommittee. He also said that the co-chairs will meet with leadership regarding streaming future

meetings. He encouraged people to submit emails to the co-chairs regarding other issues for the task force.

The next meeting was scheduled for Tuesday, October 4, 2011.

This meeting was adjourned at 4:00 p.m.