MINUTES
(Subject to approval by the Task Force)

Health Care Task Force
October 4, 2011
Capitol Building, Boise Idaho
East Wing, Room 42

In attendance were Co-chairs Senator Dean Cameron and Representative Gary Collins; Senators Joe Stegner, John Goedde, Patti Anne Lodge, Tim Corder, and Dan Schmidt; Representatives Sharon Block, Fred Wood, Janice McGeachin, John Rusche and Elaine Smith. Senator John McGee and Representative Carlos Bilbao were absent and excused. Legislative Services Office staff members present were Eric Milstead, Mike Nugent, Matt Ellsworth and Charmi Arregui.

Others present at the meeting included Senator Nicole LeFavour; Representative Phylis King; Former Representative Margaret Henbest; Ashley Morrison, Andrew Drewiskc, Tim Birch and Elizabeth Adams, Boise State University Nursing Program; Ross Borden, City of Boise; McKinsey Miller, Gallatin Public Affairs; Benjamin Davenport, Risch Pisca PLLC; Scott Leavitt and Jim Genetti, Idaho Association of Health Underwriters; Corey Surber, Saint Alphonsus; Woody Richards, Blue Cross; Kris Ellis, Benton/Ellis; Steve Rector, Pinnacle Business Group; Marilyn Sword and Christine Pisani, Idaho Developmental Disabilities Council; Heidi Low, American Cancer Society/Cancer Action Network; Susie Pouliot, Idaho Medical Association; John Watts and Elizabeth Criner, Veritas Advisors LLP; Skip Smyser; Bill Roden; Director Bill Deal, Eileen Mundorff and Tom Donovan, Department of Insurance; Amy Holly, Sullivan Reberger Eiguren; Marnie Packard, PacificSource; Sarah Fuhriman, Roden Law Office; Hyatt Erstad, Idaho High Risk Reinsurance Pool; Kathie Garrett, Partners in Crisis; Molly V. Prengaman; Jodi Osborn, Leslie Clement and Dave Taylor, Idaho Department of Health and Welfare; Moriah Nelson, Tim Heinze, Denise Chuckovich and Jesus Blanco, Idaho Primary Care Association; Shad Priest, Regence; Bill Hoffman, Idaho Main Street Alliance; Mike Brassey, St. Luke's Health System; Jim Baugh, Disability Rights Idaho; Charlie Novak, M.D., Heidi Hart and Paul Woods, Allumbaugh House; Amy Lorenzo, Office of Performance Evaluations; Jean De Luca, Dental Dental of Idaho; Jayson Ronk, Idaho Association of Commerce and Industry; Ray Stark, Idaho Chamber Alliance; Wayne Hoffman, Idaho Freedom Foundation; Lyn Darrington, Regence BlueShield of Idaho; Steve Thomas, Idaho Association of Health Plans; and Penelope Schwiebert, Idaho Health Insurance Exchange.

The meeting was called to order at 9:06 by **Co-chair Collins**; he welcomed everyone and called for a motion on the August 22, 2011 minutes. **Senator Cameron moved that the August 22, 2011 minutes be approved, seconded by Senator Schmidt and the motion passed unanimously by voice vote.**

The first presenter was **Paul Woods**, Environmental Division Manager, City of Boise, who updated the task force on the Allumbaugh House's first year offering sobering, detox and crisis

mental health services. His PowerPoint presentation entitled "Planting seeds of change" is on LSO's website at:
www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1004_woods.pdf.

Mr. Woods said that Allumbaugh House had been in operation for about a year; prior to that, Franklin House, a mental health crisis facility, operated for about ten years and was funded through the Department of Health and Welfare (DHW). That facility was very successful in diverting mental health crisis cases to a more stable condition, saving community resources, but it did not address those with substance abuse or detox needs. Allumbaugh House focuses on community interest in a detox facility, combined with the Franklin House concept as a mental health crisis facility; many people are co-concurrent with both conditions, so Allumbaugh House delivers more services. The governance is shared through a joint-powers agreement and parties include the state of Idaho, Office of Drug Policy; Ada County; the city of Boise; and the city of Meridian. Private partners include St. Lukes and St. Al's Hospitals, as well as United Way. The Allumbaugh House building is owned by the Ada County-Boise City Housing Authority and the operation is conducted under a contract with Terry Reilly Health Services, operating under a licensing agreement from DHW, thus being a licensed medical facility. Data collection is very important to the operation of Allumbaugh House, and services include crisis mental health, detox and sobering. The average length of stay is five days; 74% voluntarily stay to successfully complete treatment and 10% are repeat clients. $1.8 million was the operating budget, 44% funding coming from the Office of Drug Policy, having been reduced to $787,000 and in FY 2011-2012 one-time money was used from United Way as part of the Albertson's fund-raising effort to bridge that funding gap. In FY 2013, Allumbaugh House will be out of those funds and looking for operating funds for patient care. An average night's stay in an emergency room is about $1,500 compared to Allumbaugh House's cost of $240 per night, thus saving community resources, in many instances. Funding challenges include securing a $1.8 million operating budget for FY 2013. Allumbaugh House has operated at or above capacity for the mental health and detox services since opening, and they continue to look for ways to partner with other entities to provide complimentary services, and are looking for sustainable sources of funding. **Mr. Woods** thanked the task force for their leadership and said that Allumbaugh House considers itself to be a regional model, and other counties have toured the facility.

Senator Schmidt inquired about trying to quantify savings; since Allumbaugh House serves a regional area, it seemed to him that hospital diagnoses could be looked at to see if there are less hospital stays for alcohol or substance abuse and actual savings could be documented to DHW. If Allumbaugh House is saving the state money, documented data would be most helpful to everyone. **Mr. Woods** replied that they are looking at ways to present accurate data; Health Insurance Portability and Accountability Act (HIPAA) requirements limit looking at some data. **Dr. Charles Novak**, M.D., Co-Medical Director, Allumbaugh House, said the biggest complication in trying to keep data is that there is a continual flow of patients through the emergency rooms, hospitals, community mental health centers, jails and other entities, and the safest thing to say is that when looking at the $9 million number (total annual savings compared to hospital stays), most people at Allumbaugh House complete treatment and don't end up in the

hospital. Without Allumbaugh House, he estimated that 100% of these patients would end up in the hospital, believing that millions of dollars are being saved.

Representative Rusche said that another place to look is the county for acute mental health and substance abuse admissions to compare costs per case, believing that big bucks are being saved. **Heidi Hart**, Behaviorial Health Director, Terry Reilly Health Services, replied that they have been working with Ada County **Commissioner Yzaguirre** on this issue for Region IV to really look at how indigent services have been impacted since Allumbaugh House started operating. When indigent patients do not come to Allumbaugh House, they are looking at how to improve the referral process. Since indigent files cannot be examined, legal hurdles prevent data from being gathered and shared. **Dr. Novak** added that 95% of patients at Allumbaugh House have no insurance, Medicare or Medicaid, so these patients would end up costing counties dollars.

Representative Wood asked if Allumbaugh House had adequate funding and how many more patients on an annual basis could they take over last year. **Ms . Hart** answered that licensed bed capacity is for 28 people and they have had about 14-18 people. **Representative Wood** asked if that constraint was due to funding and **Ms. Hart** said that capacity is 28 and what keeps them from getting to 28 is funding. She said the building was designed with a floor plan that could double that capacity.

Leslie Clement, Deputy Director, Medicaid, DHW, was asked to give an update on the Molina system and her PowerPoint presentation is on LSO's website at: www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1004_clement1.pdf.
Ms. Clement said that in July 2010 the acceptance rate for claims submitted was at 75% and in September 2011 that has increased to 92.9%, that being an indicator that the Molina system is performing appropriately. Medicaid normally pays out $24 million in funds weekly, and currently $22-23 million, which is good news for the budget. Numbers of claims went from 88,644 in July 2010 to 140,698 in September 2011, proving that the Molina system is now working. **Ms. Clement** said that workable inventory proved that the system was not doing its job during early implementation since payment within 30 days is the standard, and the inventory backup was huge; in January 2011 there were 33,000; claims peaked to 65,538 in May 2011 and in September 2011 decreased to 6,617, an excellent amount of claims being worked. Customer service complaints decreased considerably. The abandoned call rate in July 2010 was 50% and is currently 1.8%; the wait time decreased from 38 minutes, 19 seconds to 30 seconds currently. Interim payments totaling $117.9 million were made by the state to providers in an attempt to approximate what they should have been paid if claims had been accurately processed. As provider configuration issues were corrected and claims were accurately processed, the state began actively recovering interim payments in January, 2011, and 4,500 providers paid interim payments. Interim payment recoupment has gone from $118 million down to $6.6 million in September 2011, still outstanding from providers. The state does not expect to assume responsibility for any of those outstanding payments, one point at issue currently with Molina.

The Molina system is operating well, even though not perfect, having made great progress. The centers for Medicare and Medicaid (CMS) need to come to Idaho to certify this Molina system, which is a required step for systems and they anticipate a November on-site visit. The objective is to get certification back to the go-live date and the risk is, if the system is not certified back to the go-live date, the match will change from 75% federal funding under a certified system which could drop to 50%. They believe that many months will be certified, except perhaps for the early months, and discussions have taken place with Molina if a gap occurs which might amount to $450,000.

Ms. Clement said there are other major system requirements such as 5010 HIPAA (underway); a version update (underway); federal transaction requirements in pharmacy system (targeted to be implemented 1/1/12); HB 260 changes (majority completed and implemented); and federal procedure code changes called ICD 10 having to do with diagnoses codes (implementation in October, 2013) which expands numbers of diagnoses codes within a system and is a health plan requirement.

Representative Rusche asked about ongoing accuracy data with regard to transition issues mentioned by **Ms. Clement**; he asked if the contractor can provide accuracy data on claims processed. **Ms. Clement** answered that they are focusing on having a good quality assurance process in place. In hindsight, she said possibly the biggest failure in the implementation of Molina was not adequately checking things before being implemented, through testing and retesting. Improvements have been made and all these changes and requirements are sufficiently being tested in a number of scenarios before being implemented. Finding the root cause of any issue and addressing that is also key, and gives DHW more confidence moving forward. Upcoming changes will have to be implemented differently than in the past. **Representative Rusche** suggested that the accuracy data is equally as important as inventory and number of claims processed; he asked DHW to include accuracy data in future reports.

Representative Wood referred to ICD 10 (federal procedure code changes to be implemented in 2013) saying that for many health plans and other providers, the cost of this implementation is absolutely staggering in terms of hard dollars out and manpower due to technology changes that must take place; he asked how DHW was dealing with this project and does DHW anticipate any increase in funding for this and will DHW be asking the Legislature for more money. For many institutions, this could create a black hole they are not even aware of at this point in time. **Ms. Clement** answered that DHW's efforts and staffing for this project have begun. In terms of the coded information and costs related to computer programming, Idaho has in its favor the fact that those are on the back of the vendor. DHW negotiated the contract knowing that there are always new federal requirements and DHW let the vendors know that they are responsible for incurring costs to implement these federal requirements. DHW does have a budget request coming before the 2012 Legislature asking for funds for other costs, such as project staff, operations staff, and updating manuals. **Representative Wood** asked about outreach and what kind of interface DHW will use with small, private providers, since many are not even aware of these coming changes,; he said he feared the Molina system debacle all over again. He asked what kind of

educational program DHW will use to inform all these providers now, which could already be too late. **Ms. Clement** answered that DHW will come back to the task force with a readiness response.

Senator Corder commented that changes become administrative burdens to senior centers who have reported to him that Medicaid eligible participants had been reported on one form and now there is a form to report each individual monthly, causing a very significant administrative burden; he had been trying to get to the bottom of this problem. **Ms. Clement** agreed to get specific information about this issue.

Senator Goedde stated that Molina has a counterpart doing similar work, asking **Ms. Clement** if she had similar numbers on that and **Ms. Clement** said she assumed he was asking about the system performance of "Idaho Smiles" and he affirmed that; **Ms. Clement** agreed to get that information. **Senator Goedde** said that some providers stepped away from the program due to the mess they found themselves in when Molina was instituted; he asked if any of those providers came back. **Ms. Clement** said she was not aware of this and said it would be helpful to know the names of providers who withdrew, adding that she would look into this situation.

Representative Collins asked about the recoupment of interim payments and the $6.6 million balance in September 2011, asking if some of these businesses were in bankruptcy or went out of business and about the negotiations with Molina with regard to these delinquent funds. **Ms. Clement** said DHW knows exactly who has not paid, amounts due, and whether they are still providing services to Medicaid patients, but she did not know if DHW has the status of businesses filing bankruptcy unless that business had informed DHW of that. One challenging area is providers who stop being a Medicaid provider for reasons such as a certified family home provider who had a Medicaid patient who died or moved. If, at the end of the state fiscal year, there is an outstanding amount of interim payments not yet recovered, DHW has had the conversation with Molina informing them that DHW will be looking at Molina to make that right, and a response to that has not yet been received from Molina. There are complications as to who might be liable, since Molina bought the system from Unysis. DHW has currently not ended up in any lawsuits over this, and DHW wants to work with Molina in finding a resolution to avoid a lawsuit. Molina has been informed by DHW that they are on notice in three areas; interim payment recoupment has been successful thus far, and **Ms. Clement** believes that any liability will be small.

Senator Schmidt stated that there are administrative costs for recoupment of interim payments due to lack of function of the contractor, and asked if the contractor should be liable for those costs also. **Ms. Clement** said that Molina had acted as a partner in recovery of these interim payments to date, so Molina has incurred those administrative costs, but she said that DHW would consider this if DHW ends up in a situation where an agreement cannot be reached.

Senator Cameron wondered if DHW makes an effort to visit with providers regarding call center wait times; as he talks to providers, long-term care facilities, and hospitals, they say the

call wait times are a little better, but not much. He wondered if DHW makes an effort to reach out to providers about existing problems with Molina. He commented that DHW is very confident DHW will receive CMS certification, asking what will happen if the state doesn't. **Ms. Clement** answered that metrics presented here do not necessarily speak to quality, but were data points tracked from day one with Molina to show progress. DHW does track other metrics as well, including all visits to providers on a weekly basis and all meetings with providers, providing a forum to address issues. Some providers have said with the improvement in service, weekly visits were not necessary with DHW, moving to a monthly basis or less. Efforts are being made with any problem situation, and DHW sends Molina staff to a site to walk through issues or to do training and this has been tracked and services significantly improved. **Ms. Clement** stated that if the system is not certified, that gap between the 75% and 50% match would amount to $450,000 in state general funds. **Senator Cameron** commended DHW for being as successful as they have been; looking back, he asked what DHW thinks could have been done better and what has been learned, admitting that legislators bear some of that responsibility. **Senator Cameron** thinks that JFAC should have insisted that simultaneous systems be run for the first few months; another thing that could have been done with regard to contracting provisions, an entity should never be allowed to sell a contract thirty days prior to taking over a business, which he sees now as total foolishness. He asked if DHW has gone through that analysis and, if so, what other items should be on that list. **Ms. Clement** answered that everyone has wondered what could have been done to change the situation that occurred with Molina; she said DHW knew it was a "perfect storm" as they moved toward implementation, especially since DHW had held provider payments for three weeks for all providers and almost two months for hospitals and nursing homes. **Ms. Clement** said she would certainly revisit the timing of implementation, allowing payments to get out the door before expecting the new system to start processing claims, creating an added stress that made it much worse for everyone. Testing was done and providers were invited to test with DHW, but very few did test, and more focus should have been put on testing and retesting before going live. The other issue moving from one system to the next was the hardware maintained by the EDS vendor at the time whose warranty was expiring, and one mainframe system did crash. DHW has looked at everything and DHW admits that testing and live piloting should have been foremost.

Senator Stegner asked about the potential liability for not receiving CMS certification; he said he assumed this risk was known when DHW went through the transition, asking if there was any discussion at that time whether Molina was going to guarantee that certification and if Molina has joint liability, if not certified. **Ms. Clement** said, in her opinion, it is Molina's responsibility and liability and DHW has documented that to Molina, so the process will continue to see what occurs. Molina knows this is the state's opinion and that lack of certification rests clearly on Molina; there is no budget request coming to JFAC, and if any gap in certification, that is Molina's responsibility to cover. In addition, before Molina went live, DHW requested from Molina executives a letter confirming that the system was ready to go live, so DHW has Molina assurance that the system was capable of meeting requirements. There is risk, but the risk will be managed between DHW and Molina, and DHW looks to Molina for coverage.

Representative Rusche commented that OPE did a study that pointed out several opportunities, not specific to DHW and Medicaid in contracting, that noted lack of expertise in supervising major systems transformations at the same time staff was downsizing. He believes there are real lessons here, especially with changes going forward and also in the educational realm and technological changes in the state, to learn from past mistakes.

Representative Wood commented that an update on ICD10 needs to be received before session starts; he hopes that everyone learned from the Molina incident, pointing out that as Molina went live, less than 50% of providers had signed up. The real issue now is a real federal government date, not a state date, and unless CMS changes that, there are many small providers who will literally not be paid come October 1, 2013 if they are not on board with the changes required. There needs to be an educational system in place now to prevent a similar issue from occurring in 2013.

Ms. Clement next updated the task force on Medicaid reforms in response to House Bill 260 and her PowerPoint presentation is on LSO's website at: www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1004_clement2.pdf.
Ms. Clement pointed out one area which has changed from her last report to the task force, that being pharmacy reimbursement (cost of the drug and dispensing fee); she said as of September 28, 2011 ingredient cost for drugs is now paid using the average acquisition cost. Generics were implemented in July, 2011 and single source drugs were added in September, 2011. DHW has also implemented a tier dispensing fee based on the results of cost surveys, and she said that DHW expects to exceed savings projections, about $2 million in state general funds and hopefully $3.5 million dollars in this area. The (actual) average acquisition cost methodology is pricing based on actual invoice information collected as part of the ingredient cost survey. About 195 pharmacies in Idaho are chain pharmacies and 162 are independent. House Bill 260 gave DHW direction that not all dispensing fees should be the same, since chain pharmacies have bigger volume and dispensing costs are less. This resulted in prescription volume between zero to 39,999 had a bigger average price of $15.11 compared to 70,000 volume and higher at average price of $11.51, and average dispensing costs were similar.

Ms. Clement said that Medicaid mental health changes included reduction of adult PSR from 5 hours/week to 4 hours/week and in July 2011 DHW implemented a management tool for review of PSR services to ensure appropriate delivery, adding that there had been no other system or policy changes since that time. Developmental disability services included looking at budgets in April 2011, and she said DHW feels confident that methodology is in place to ensure people are getting needs met within budgets. Projected general fund savings amounted to $2,000,000. DHW blended the rate for adult developmentally disabled and individual, a recommendation from a provider to legislators last session, implemented in July 2011 and projected general fund savings amount to $1,100,000. **Ms. Clement** said that House Bill 260 directed that no rate increases for Medicaid reimbursement occur for SFY 2012 and those changes were implemented in July 2011, projected general fund savings amount to $4,700,000. DHW set reimbursement at 90% of Medicare for non-primary care procedure codes in July 2011, with projected general fund

savings to be $1,500,000. There will be a budget request coming in 2013 that is only federal funds, a change under the Affordable Care Act, that uses federal funds in total to take all primary care rates up to the Medicare rate, but will have no state general fund impact. DHW will be making changes in therapy services in January 2012, projected general fund savings of $200,000. In July, one therapy change reduced outpatient hospital therapies to 90% of Medicare, projected savings of $300,000. Dental changes all went into effect in July 2011, projected savings being $1,700,000. **Ms. Clement** pointed out many other services and cost sharing (co-pays) which have been or soon will be implemented. Continued reductions from 2011 (HB 701) were made permanent by rule authority. The Idaho Home Choice Project provides transition funding for individuals from high-cost institutions to move them into community settings, implemented in October 2011, projected general fund savings of $1,300,000. Certified family home fee changes were implemented in July 2011, $176,000 was collected to date, and only 134 homes have not yet paid. DHW can terminate for failure to pay the certification fee, but hopefully DHW will not revoke anyone's certificate. With regard to program integrity, DHW did implement edits into the Molina system to ensure accurate payments, and projected savings of $50,000 will be exceeded, and edits are being tracked. Eight new additional Medicaid integrity staff (under support services, not Medicaid Division) have been hired and projected savings amount to $1,100,000. Collection of assessments are all on target, projected savings amounting to $7,500,000.

Ms. Clement reported progress on managed care (56-261) Medicaid cost containment and Health Care Improvement Act and (56-263) Medicaid Managed Care Plan that focuses on high-cost populations to improve care and coordination. House Bill 341 directed Medicaid to complete an actuarial analysis of all Medicaid plans by population, subgroup and region and to provide a copy of that report to DFM by December 1, 2011, which will provide good data to help inform decisions as DHW moves forward. DHW continues to work on medical homes/health homes to improve care coordination. Commercial payers are proposing a pilot scope that focuses on the high-risk population; some tension has resulted in the desire to transform medical practices to see what can be done to improve care for a certain population. There is much information about identifying underlying mental health issues, then other diseases can be brought under control, which gives a huge return on investment. **Ms. Clement** said DHW is establishing managed care for behavioral health benefits starting with Medicaid mental health services. A website has been set up for the public to submit information about concerns and recommendations at: www.MedicaidMHManagedCare.dhw.idaho.gov.
DHW is planning for the transition from a fee-for-service environment to a capitated environment which goes to the managed care entity, not to provider, which should improve the current system. DHW is also focusing on dual eligibles (individuals who have Medicare and Medicaid) that reflect a small fraction of the enrollment in Medicaid programs and almost 50% of the cost. In Idaho there are 17,000 individuals in that dual-eligible category. Many are at the table working with DHW to administer a program on managed care to include long-term care services and there is a website at: www.MedicaidLTCManagedCare.dhw.idaho.gov.
Ms. Clement said that DHW has invited Oregon and Utah managed care experts to share their state's Medicaid managed care experiences in early November, since those states have had Medicaid managed care for thirty years and they can inform about what worked and what didn't,

as well as to inform legislators and allow them to ask questions. Oregon and Utah are now reforming their managed care and their advice could be extremely beneficial. DHW is working on a medical public forum to the Idaho Medical Association, the Idaho Hospital Association and the Idaho Primary Care Association to ask them to work with DHW and the state to host a full-day forum to discuss how those health care providers want to see Medicaid implement managed care. Invitations will be sent to legislators and the public for a forum to be held in December, 2011. **Ms. Clement** ended her presentation by saying that she will have a HB 260 report to the Legislature that will include actuarial analysis results, the summary of all the 2012 activities regarding development and recommendations.

Representative Rusche asked about the pharmacy presentation and how the survey cost compares with the commercial market and **Ms. Clement** answered that the two components could not exceed the commercial health plan cost to a pharmacy; overall, Medicaid is paying the lowest for those pharmacies. **Representative Rusche** thought that cost seemed extremely high and **Ms. Clement** said that the definition of dispensing fees is in federal law, so DHW follows those. **Representative Rusche** asked about managed care development and if DHW was contracting for actuarial services or using staff and **Ms. Clement** replied that DHW contracts for those services with Milliman. **Representative Rusche** asked if each year with risk sharing and ongoing actuarial services, is it the intent of DHW to contract and **Ms. Clement** answered that DHW has an actuarial contract in DHW's base appropriation and she expects DHW will continue with Milliman. **Representative Rusche** asked about developing and managing managed care contracts with national or local managed care companies; he was concerned about expertise in working with contractors who have done this previously. **Ms. Clement** said that DHW realizes that this changes the nature of jobs when overseeing contracts; Arizona has been identified as a state that has done this well, and she agreed this is one risk Idaho must pay attention to. DHW does not have that state staff competency today. **Senator Corder** asked how DHW anticipated reporting and quantifying integrity of staff and **Ms. Clement** answered that everything is tracked, from civil monetary penalties and fraud cases identified to recoveries, and a very good reporting format is in place currently for identifying what returns come in related to specific investigations. **Senator Corder** asked if DHW would be able to track the eight additional Medicaid integrity staff members and whether hiring them will pay off. **Ms. Clement** said she will be looking for this information from that office.

Representative Wood said that HB 260 tried to specifically peg Medicaid provider rates to Medicare because Medicare does an ongoing cost of doing business and inflation analyses. He wondered why the state would go to the expense of repeating all that. If Congress doesn't resolve that issue, on January 1st there will be a 29% decrease in all provider rates. He asked what kind of issue the state is going to face if Congress does not act; would statute need to be changed. **Ms. Clement** answered if Congress lets that occur and that great reduction in Medicare occurs, DHW will need to come back to the table and talk about whether to follow suit and reduce Medicaid reimbursement by that same percentage amount or if that would create such access issues in the state that the state would be in violation of the federal Medicaid law. This is tough for DHW to take a position on; if that change is made, the state will be faced with that

decision. **Representative Wood** asked about the expense to the state if Congress fails to act and if the state would then change its system to the lower reimbursement rate. **Ms. Clement** said she did not have the savings projections on that reduction, but offered to get that information.

Dave Taylor, Deputy Director, Support Services, DHW, gave a budget update to the task force and his PowerPoint presentation is available on LSO's website at: www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1004_taylor.pdf
Mr. Taylor shared that DHW ended SFY 2011 without having to hold payments to Medicaid providers; DHW utilized $37.9 million in Millennium Funds for Medicaid T&B (trustee and benefit) expenditures; DHW reverted $1.1 million in general funds. He referred to a detailed chart in his presentation about FY 2013 proposed decision units which is a preliminary report and subject to change. DHW's budget request for SFY 2012 and 2013 include:

- Supplemental Appropriation: A change to the appropriation that adds to or adjusts spending authroity in the current fiscal year (SFY 2012);
- Maintenance of Current Operations: Resources needed to continue current levels of service (SFY 2013);
- Line Items: Additional decision units requesting funding for new or expanded activities after maintenance of current operations (SFY 2013).

Mr. Taylor said that 2011 actual expenditures for Medicaid Division were $1.9 billion, all remaining divisions $431 million, and total spent for all of DHW was $2.3 billion. For 2012, Medicaid is estimated to go down to $1.8 billion, remaining divisions $469 million, and total $2.3 billion. For FY 2013, $2 billion was requested for Medicaid, remaining divisions $445 million, totaling about $2.5 billion.

Senator Cameron inquired about supplementals, being unexpected expenditures; he asked, besides the unexpected, what was the additional request for. **Mr. Taylor** answered the additional request was for MMIS certification; DHW made a request in 2010 for those funds but was asked to wait until the system was ready to be certified, adding that the letter for CMS certification just went out one month ago. Another point of interest is that normally, with a project, there would be a 90/10 match and this was actually a 75/25 match because CMS considers certification an operational cost rather than a project process.

Representative Rusche said he didn't see a cap on supplementals, asking if that was expected to go up and **Mr. Taylor** replied: "That is actually outside DHW."

Senator Cameron, with regard to the work-in-progress Medicaid T&B shortfall, asked for a ball-park range figure and **Mr. Taylor** said he could provide that, but added that on the supplemental initially requested, he thought the general fund total was about $4.2 million. The total request was about $6.8 million because there was a reduction of federal authority in dedicated funds. **Senator Cameron** asked if he anticipated the adjustment going up or down, and **Mr. Taylor** said he hoped for a reduction.

Director Bill Deal, Idaho Department of Insurance (DOI), presented next and his PowerPoint presentation is on LSO's website at:
www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1004_deal.pdf
Director Deal was asked to update the task force on health care reform in exchanges, stating that he would discuss four issues:

- Rate review;
- Legislation to be proposed, having to do with rate review;
- Litigation that the state is involved in with 26 other states;
- Application recently submitted for a First Level Exchange Grant.

Director Deal said that rate review was important because it is a way to retain state-based regulation. CMS determined that Idaho did not meet the criteria and made the decision that the rate review would be done at the federal level, rate increases in excess of 10%, and that beginning September 1, they would be the reviewing body. The big issue was to maintain state-based regulation so a re-evaluation was requested of that decision. Insurance companies also thought that rate review needed to be on the state level and a request was submitted, the action plan to be put in place if state-based regulation could be maintained. CMS did decide on August 24, 2011 that CMS would accept the plan and it would be satisfactory for a rate review program. DOI released a bulletin to outline the agreement made with insurance companies and submitted to CMS/HHS to have the health insurance insurers continue to submit rate filings with DOI prior to the implementation of rates. If the insurance company was going to request a rate increase of more than 10%, additional information was needed. Health insurers were notified to submit rate filings to DOI and to HHS prior to implementation of the rates and if the increase was 10% or more, justification had to be provided. This was part of the plan, as well as an actuarial memorandum needed to accompany rate increases. As part of the effective review, DOI will review parts I and II as to the reasons and make justification if the rate increases 10% or more. Once DOI has reviewed that rate, then the review is complete and determination is made for the reasonableness of the rate, and that is shared with HHS and the public. Part of the law regarding proprietary information is what is talked about in the proposed legislation. Next session, proposed legislation will come forth for changes in sections 41-4706 and 41-5206, Idaho Code, to make rate calculations more transparent. A very thorough review of small group rates and individual rates will make sure these rates are in compliance with Idaho law; when a concern is identified, those rates are sent to a consulting actuary. If a problem is found, a rate could be disapproved and the insurer would be asked to correct that rate. DOI has done a good job because insurance rates in Idaho are some of the lowest in the country, particularly small group rates.

The litigation Idaho is involved with includes 26 other states; Judge Vinson ruled the requirement that individuals buy health insurance is unconstitutional and that the entire health care law must be declared void because the requirement is linked to other parts of the law. The Eleventh Circuit ruled that individual mandate is unconstitutional. This is where the law sits at the current time, but there have been updates this past week. The Federation of Independent Business asked the Supreme Court for a speedy ruling in their case and to uphold that decision

just one day after the Obama Administration chose not to ask the Eleventh Circuit Court of Appeals to rehear the case and to review the decision that the three-judge panel made previously. **Director Deal** said that he thinks the Supreme Court now has to decide whether to take this politically charged case in the middle of a presidential campaign. The retired Supreme Court Justice John Stevens said that voters would be better off if they knew the law's fate before casting ballots next year for the presidency, and that the Justices would not stay away from deciding the case, so perhaps this case will be on the Supreme Court's agenda beginning this month.

With regard to the exchange movement, **Director Deal** said that there are now 15 states participating in the health exchange that have enacted legislation to implement health care exchanges, 3 have enacted exchanges by executive order, 4 have legislation pending, 15 introduced legislation that failed, and 10 states have no proposed legislation. Two existing exchanges are in operation currently, in Utah and Massachusetts; Vermont is trying to put forth a single payer system.

In order for Idaho to implement an exchange, **Director Deal** showed a chart reflecting the many partnerships and cooperation this will require between all interested parties in the state. The primary customers in an exchange are individuals and small businesses; insurance companies write policies, underwrite and pay claims; strategic partners would be DOI, DHW, the Legislature, health insurance companies, stakeholder organizations, consumers and employers. **Director Deal** said that DOI and DHW have completed planning for health insurance exchanges; Idaho is now eligible to apply for the First Level Implementation Grant; DOI and DHW requested from Governor Otter authority to apply for the HIE Implementation Grant and he granted that authority on 9/20/11 to apply for federal funding to implement an Idaho exchange. Governor Otter said it was a difficult choice, but found it preferable to submitting to a federally established insurance exchange with loss of control over our own destiny that entails. The goal, he said, is to establish a state-based exchange emphasizing free-market principles and to create a competitive marketplace for individuals and businesses.

Director Deal shared eleven areas that had to be considered for the Level One Grant which were: background research; stakeholder consultation; governance; program integration; exchange IT systems; financial management; oversight and program integrity; health insurance market reforms; providing assistance to individuals and small businesses, coverage appeals and complaints; and business operations of the exchange; the total cost was estimated to be $30.9 million, the amount of the grant applied for. The above eleven components were broken down into the following five functions: consumer assistance; plan management; eligibility; enrollment; and financial management.

Director Deal ended his presentation by summarizing these challenges:

- Retaining state-based regulation and preserving Idaho's authority in the exchange by not defaulting to a Federal Exchange;
- Maintaining Idaho's consumer-centric focus and orientation;
- Leveraging Idaho's existing system, knowledge and technology;
- Continuing to be proactive and building what is good for Idaho;
- Continuing to rely on Idaho's many important stakeholders.

Director Deal pointed out that DOI, DHW and many organizations and insurance companies have been planning and have formulated a foundation to follow for an exchange to be created, as well as drafting legislation to be presented to the Legislature when the 2012 Session begins. Money from the grant will be available for implementation, so the Legislature will have two decisions to make: (1) evaluate the implementation legislation and pass it, and (2) to evaluate the grant money and allow that money to be spent so that implementation can begin.

Representative McGeachin asked what is the current accreditation process of qualified health care plans in Idaho now. **Director Deal** said that if she was talking about when an insurance plan is approved in Idaho today, the criteria must comply with federal law and HIPAA and also criteria in statute, such as mandates. Plans are submitted to DOI, reviewed by the rates and performance department and, if the plan complies with federal law and statute, then they are approved. **Representative McGeachin** asked if the application process currently resides within the state and **Director Deal** answered "yes." **Representative McGeachin** referred to a copy of the rules where it said that accreditation of the qualified health plan issuers shall be accredited on the basis of performance by an accrediting entity recognized by HHS (Health and Human Services) and lists a number of things for consideration. She asked if this accrediting process will have to be recognized by HHS and no longer with the state, and if any of the requirements listed for consideration were in addition to what is already being done. **Director Deal** responded that in the components mentioned earlier, such as review and complaints for accessibility, these things are currently in place; he said it was very important for Idaho to retain the opportunity for rate and policy review, so some things are in addition to what is done today. However, he said it was his understanding that the state does have the right to review the new policy plans and, as long as essential benefits are involved, then the state can approve those plans and report that to HHS.

Senator Goedde announced that he would be attending the annual meeting of the National Conference of Insurance Legislators November 17-20, 2011, with a day spent on health exchanges, and said he would bring back that information to the task force.

Senator Cameron asked **Director Deal** about the lawsuit; he said the Eleventh Circuit, as he recalled, ruled on the mandate but did not rule on the remainder of the act, even though Judge Vinson said the entire health care law "must be declared void." **Senator Cameron** said this troubled him because that mandate was set to balance other components of the act, asking for an opinion or theory as to how the Supreme Court might rule. **Director Deal** said his opinion was that the lawsuit that Idaho and other states were involved in was aimed at just the mandate to purchase, so Judge Vinson went beyond that provision in the lawsuit because it is the connectivity of the mandate; the mandate, or not having the mandate, affected the whole program, so as he interprets this, Judge Vinson made a broader decision than what the lawsuit was really about. There have been various lawsuits and decisions around the country, and **Director Deal** said he had no opinion about what the Supreme Court will do, and it is an issue. If it comes down to just the mandate, then immediately Congress will have to have some type of match to shore this program up somehow. **Senator Cameron** said his concern was, if the mandate is found unconstitutional, then other provisions could be affected such as the reduction of plans to the "medals' plans" which are requirements of the exchange. There is a litany of

provisions such as rate review, and those all still stand in place. He said he hears others say that if the Supreme Court throws out the mandate, the whole thing is out, and he believes that is an unknown at this stage, and may not be the case. He asked about the dollar breakdown on the grant, expressing his surprise that out of the $30.9 million, only $8,263,000 was going toward IT technology and $16,683,000 toward business operations of the exchange. He asked for explanations on these amounts since Director Armstrong, DHW, seemed to think that a much larger portion of that grant would be going toward IT systems to comply with either the federal or state portion, asking if he'd misunderstood. **Director Deal** answered that many issues having to do with IT systems also are a part of business operations, such as the processes, the cores of the eligibility determination system, and attachments of the system. **Senator Cameron** asked that DHW get back to him regarding whether the $8,263,000 for IT is simply the nuts and bolts of making the system work and what part of the $16,683,000 for business operations may include IT processes. **Director Deal** agreed to get this breakdown for **Senator Cameron.**

The task force placed a conference phone call to **Joy Wilson**, National Conference of State Legislatures (NCSL), and she addressed efforts of state governments to comply with federal health care reform. **Ms. Wilson** said that many other states are where Idaho is right now, trying to make difficult decisions about whether the state or HHS will run the program and more states are deciding to be in the driver's seat, even with reservations about the underlying program. In the last month, Michigan, New Mexico and others have requested establishment grants. Accepting those grants does not commit a state to establish a state-based exchange, but is a signal that a state intends to move forward with a state-based exchange. She said it's a guessing game about what the Supreme Court and Congress might do as part of debt reduction, and where the public is with regard to their support for the overall program. Across the country, the small business community has taken a lead role in suggesting the state exchange would be preferable to HHS. Comments are due at the end of October, 2011 on some of the major regulations to set guidelines for operating an exchange, and NCSL will be a part of that, to make sure that states will have a primary role in the operation. **Ms. Wilson** invited all states to weigh in with any particular concerns.

Ms. Wilson said that there was not a fiscal benefit package, adding that this was very important. If a state has mandated benefits and, if those are not within the essential benefit package, that state will either have to repeal those mandated benefits or pay for them. Unfortunately, it is not likely to see a proposed rule on the essential benefit package until late December, 2011 or January, 2012, which presents a problem. Timing and guidance are of utmost concern; if states are going forward, they need information which is coming forth slowly, making it difficult for states to put together supportive legislation. NCSL urges HHS to move as quickly as they can to get to the "must do's" so states can know exactly what is necessary to move forward; once a legislature adjourns, this is the last session before the January 1, 2013 deadline for a state to be ready to move forward. Of importance, there is some 90/10 money for updating the Medicaid IT infrastructure, so some of that will be used to help the exchange and may be an offset to the amount requested in the establishment grant. To the extent that the 90/10 money for Medicaid management information system would also help in anything done otherwise in DHW and IT, some requirements have been waived to charge those other programs for upgrade, so that is very important money. States that have passed legislation don't give a good sense of where they are because many states are proceeding without legislation, such as Idaho has, and that doesn't often

show up. She offered to send the task force a document which she has updated with regard to where all the states are currently.

Senator Cameron asked about IT systems and the 90/10 match. Regarding the $8.2 million Idaho was planning on using from the grant for IT systems, he asked if that is allowed to be used toward Idaho's 10% of the match or was she saying that with that $8.2 million, Idaho's general fund would have to come up with an additional 10%. **Ms. Wilson** replied that the technology money may not be related to the Medicaid side of the exchange, it may be on the insurance side. The insurance side and the Medicaid side must "talk to each other" since people will move back and forth, to some extent. Most states are going to have to do work on the Medicaid system to function that way; that money is a 90/10 match, instead of the normal 50/50 match for administrative costs. A state does not have to do that part of the exchange out of the establishment grant funds; it is separate money, she said. **Senator Cameron** asked about comments being due, and if the task force could get a copy of NCSL's comments or other states' comments; could she share what some of those comments may be, aside from flexibility, which everyone agrees is needed.

Ms. Wilson said she didn't mention one area, since Idaho wants to do a total state-based exchange, but added that the administration has come up with a third option: (1) state-based option; (2) federal HHS; and (3) a partnership approach option where states would be able to do some functions and the federal government would do other functions. In their proposal, it was limited to consumer assistance and plan management and many states wanted to split functions in eligibility and enrollment, not presented as an option. Much feedback has been received by NCSL that they want a broader array of partnership options, and NCSL will comment on that. Another item is on a part of the application process where HHS reviews state legislation to make sure the state has the authority to run the exchange, the underlying state law to support the activity required by federal law. NCSL's question is exactly how that process will work, and any time the federal government is reviewing state legislation, details are important, especially the time frame. There are some areas where the law makes it an option and the rule makes it more of a requirement, and NCSL wants to hold, if optional, in underlying federal statute to not become a requirement by rule. NCSL is looking at those kinds of things, trying to maintain much flexibility. **Ms. Wilson** said that there are other areas about how states interact with tribes, which is not very well thought out, and could be problematic; NCSL thinks additional guidance should be given on exactly how this will work. NCSL is looking at where the interest of states might not be carried through by something included in a rule. NCSL's comments will be made public, and she invited Idaho's comments. **Co-chair Collins** thanked **Ms. Wilson** for her input and said the task force looks forward to their next conference call with her. **Ms. Wilson** said there will be much more to talk about in another month since many rules are yet to be published. The Institute of Medicine, later this week, she said would submit their report to HHS on essential benefits, and that will generate comments.

The task force recessed for lunch at 11:53 a.m. and reconvened at 1:33 p.m.

A number of groups were asked to present to the task force answers to the following questions about the Idaho health insurance exchange:

1. What is your stance on the idea of exchanges?
2. Do you favor a state or federal exchange and why?
3. What provisions are important in a state exchange?
4. What should Idaho avoid?

All but one of the twelve presenters' presentations are on LSO's website under "October 4 Meeting - Additional Materials" at:
http://www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare.htm
Hyatt Erstad, High Risk Reinsurance Pool, did not provide LSO a written presentation, so his presentation is reflected only in the minutes that follow.

Jayson Ronk, Idaho Association of Commerce and Industry (IACI), said that IACI is in support of an Idaho-formed exchange that is right for Idaho. IACI supported requesting federal funding to protect Idaho's citizens from higher taxes and to safeguard Idaho's ability to control its own destiny when developing an exchange. IACI presented several pages of key elements to consider in the development of a state exchange, and recommendations, all of which are on LSO's website.

Heidi Low, American Cancer Society/Cancer Action Network, said that her group is in favor of a state insurance exchange, and that insured Idahoans should have access to quality, affordable health care, key to cancer prevention and early detection and best possible treatments, if diagnosed. Important provisions and things to avoid in a state exchange include:
- The exchange governance board needs to be properly structured to ensure that its decisions serve the best interest of consumers, patients, workers and small employers.
- Rules for the insurance market outside the exchange should complement those inside the exchange to mitigate "adverse selection."
- The Medicaid program should be well integrated with the exchange.
- The exchange should be structured to emphasize administrative simplicity for consumers.
- The exchange should have a continuous and stable source of funding.
- The exchange should have the authority to be an active purchaser.

Representative McGeachin commented on adverse selection, saying that she wasn't aware that law required any insurance products sold in Idaho had to be sold through the exchange; she asked if that was part of federal law or the position of the Cancer Society. **Ms. Low** said that was not her understanding of federal law; she was saying that to avoid adverse selection, that the exchange be able to regulate to ensure the plans are comparable inside and outside the exchange.

Senator Cameron asked about assessing carriers or fees for products both inside and outside the exchange and if that would make those who choose not to participate in an exchange pay for costs of those who are participating in the exchange. **Ms. Low** answered "yes."

Jean De Luca, President and CEO, Delta Dental, said that Delta Dental is a non-profit corporation whose mission is to improve the health of Idahoans through access to quality dental treatment, and is not an insurance company, but a professional service corporation. She said that Delta Dental supports the creation of a state exchange to provide an open marketplace, transparent to consumers, to enhance, not replace, the competitive market. A state exchange

should have the ability to adjust its operation to meet requirements to permit avoidance of a federal intervening exchange over which Idaho would have little control. Dental benefits for children are vital and "stand-alone" dental plans need to be active participants in the exchanges. Supplemental dental coverage for adults should be offered so parents have access to family coverage. Multi-line carriers should be allowed to offer medical-only policies for a range of options. The state should avoid creating requirements that minimize competition in the current market. Medical carriers should be allowed to offer their medical benefits separate from dental carriers, and costs to consumers should be transparent.

Denise Chuckovich, Idaho Primary Care Association, said they favor creation of an exchange as an opportunity for many uninsured Idahoans to access quality medical care, keeping them healthy. They favor a state exchange and think the exchange should require qualified health plans to contract with all interested community health centers as essential community providers. The exchange should also require qualified health plans to reimburse health centers no less than the amount of their Medicaid payment. It should also include at least one individual representing safety net providers on the Insurance Exchange Board of Directors. The state should avoid allowing health plans to limit the number of health centers they include in their provider network; qualified health plans should be required to reimburse health centers at their Medicaid payment rate; and do not exclude representation of the consumer's voice on the Exchange Board.

Hyatt Erstad, Chairman, High Risk Reinsurance Pool, shared that he believes it important for the state to establish its own exchange, and with regard to the future of the high risk pool, he said his concern was that currently there are two high risk pools within Idaho (1) Idaho high risk pool (has pre-existing conditions on it) and (2) the federal pre-existing high risk pool (available for individuals who currently have pre-existing conditions and have not had coverage for six months) and, with a doctor's note and recently admitted, can go into the pre-existing high risk pool. As of last month 100 people were in the federal pool in Idaho; within Idaho's pool the number is just under 1,700, and over 8,000 have gone through the pool. Looking forward to 2014, what will happen is that individuals in the federal pre-existing pool will be put into the exchange and this could have a significant impact on the risk and risk adjustment of that pool. The role of Idaho's existing pool passed by the Legislature he sees continuing on as a secondary safety net, to continue to provide coverage for those individuals currently insured or new individuals between now and 2014 coming into the pool. If exchanges become the law, he sees the role of the Idaho high risk pool changing and becoming more of a reinsurance and risk adjustment mechanism that can adhere under the ACA legislation that does require those items included within the exchange for the first three years, unless the exchange goes into effect in 2014. The Idaho pool has been extremely viable and the envy of many other states due to the way the pool is funded with reserves in place. **Mr. Erstad**'s caution was to proceed slowly with what happens to the high risk pool since so many variables are up in the air. He believes that the pool will become a perfect vehicle to comply with two of the components with regard to reinsurance and risk adjustment required by the federal law under ACA.

Representative Rusche asked how to get carriers to participate and share the cost burden and **Mr. Erstad** answered that the high risk pool for Idaho will continue on technically, since it is not impacted by the PPACA legislation. The Idaho pool could continue to run even after exchanges come into place, but this could all be changed by the Legislature. The federal high risk pool is

envisioned to merge directly into exchanges and underscores the bigger role for the Idaho pool to be a health reinsurer and work the risk adjustment models. **Representative Rusche** asked about carrier participation and **Mr. Erstad** replied that what happens in 2014 is that there will be no pre-existing conditions, no more underwriting whatsoever, but based on the risk that is ceded within or the risk that goes into the exchange, he thinks there is a viable way for some of that risk to be reinsured to prevent the viability of the exchange.

Wayne Hoffman, Idaho Freedom Foundation, said that IFF opposes the creation of a government-run health insurance exchange, be it federal or state. A state exchange would be opting to implement the federal law that IFF is suing to block on constitutional grounds. IFF wants the state to make Congress reconsider this law by not enacting it. IFF supports the Legislature getting out of the way and allowing the free market to operate. IFF believes that Idaho should avoid fooling itself into believing that it can create a limited exchange that will be just enough to escape federal oversight. IFF thinks it is up to the state Legislature to stand firm, to reject the a government insurance exchange and allow the health reform law to continue through the legal challenge in the U.S. Supreme Court.

Representative Rusche said that he did not agree with **Mr. Hoffman's** statement that the federal exchange cannot integrate with tax credits. He asked if **Mr. Hoffman** was saying that the state of Idaho should forgo any opportunity that Idaho citizens have for support for premiums through tax credits. **Mr. Hoffman** replied that the law is "miscontructed" and that the law clearly says that tax credits are available to folks in the state exchange, and this would not address that problem. **Representative Rusche** said he heard **Mr. Hoffman** say that Idaho should not develop an Idaho exchange where a tax credit could be integrated into premium support. Do you believe Idahoans should play chicken with the federal government. **Mr. Hoffman** said he doesn't support the tax credit at all since he believes it to be nothing more than redistribution of laws and we shouldn't play social engineering with federal tax policy, since he thinks there is enough of that going on in states and the federal government.

Mike Brassey, St. Lukes Health System, said St. Lukes would prefer that as many Idahoans as possible are covered by private health insurance and favors the concept of exchanges. A state exchange is favored since it would be better for Idahoans and they will be better served with a variety of competitive products; the federal government would pay the cost of connecting Medicaid to the exchange; the best approach is to allow the state to deal with it's citizens rather than relying on a federal system that may be biased against state licensed advisors. St. Lukes prefers an exchange that is open to all companies qualified to offer health coverage; is open to all health plans qualifying for sale on the exchange; and encourages creation of health plans that will make it easier for individuals and small businesses to purchase health coverage. St. Lukes thinks the exchange should provide a competitive market for health plans and governed in a way to maximize consumer choice. The state should avoid creating unnecessary limitations on products that may be offered on the exchange. The state should avoid practices that unnecessarily increase health care costs or the cost of creating and offering health plans.

Corey Surber, St. Alphonsus Health System, said that St. Alphonsus envisions a nation with affordable health care, leaving no one behind. Successful health insurance exchanges will

expand access and facilitate consumer engagement with robust transparency around price, quality and benefit designs. St. Alphonsus supports a state-based exchange, providing more flexibility, responsiveness and control. They support leveraging the federal funding for the complexities of implementation. **Ms. Surber's** handout advocated for specific components for a state exchange, available on LSO's website. Things to avoid would include focusing only on the exchange development as a solution to all health care problems; we must also focus on developing the health care work force to meet current shortages which will worsen, if not dealt with. A state-based exchange is a tool that can be used alongside delivery reforms to improve the health of Idaho's population and save money

Ray Stark, Idaho Chamber Alliance, said the Alliance represents twenty chambers around the state and they support a state exchange. Important provisions in a state exchange include: a simple one-stop shop; human interaction on the front end; requirements for packaging and pricing will provide choice and flexibility; opportunity for provider participation and reimbursement; maintain the system of independent insurance brokers; include preventive care options for business, not just catastrophic care; and fund the exchange adequately to ensure success. Idaho should avoid making the exchange a limited provider pool, don't exclude small business representation on the governing board, and avoid a computer-oriented system on the front-end. An insurance exchange is a good idea, but it must be a state exchange.

Steve Thomas, Idaho Association of Health Plans (IAHP), said that IAHP strongly favors a state exchange since DOI has a proven track record and Idaho's premium rates are some of the lowest in the country; a state exchange can be more sensitive to and responsive to needs of Idahoans and businesses; a qualified state exchange under PPACA can give Idaho consumers access to substantial and needed financial assistance (to individuals) and tax credits (for small businesses). The exchange must facilitate a competitive marketplace. It must not be a regulator, a role which Idaho law already and properly assigns to DOI. The exchange must be lean, simple and transparent to users. Idaho should avoid a federal exchange. Idaho's exchange should do no more than is minimally necessary to qualify under PPACA and receive financial assistance to which Idahoans are entitled. The exchange should not destroy the function of the producer or agent, whose knowledge and guidance are needed by consumers.

Representative McGeachin asked about IAHP representing health insurance products and a comment made that the "feds" have not come out with rules. She said that a section of rule does refer back to federal statute where it lists things required including maternity care, etc. Nobody would argue these things are good to have; however, some women past childbearing do not need coverage for maternity care, and might be something she would be paying for anyway. The way things are now in the free market, she can get a policy without maternity coverage. Also, with regard to a cost sharing requirement, in federal law that would prevent out of pocket expenses such as a deductible, there being an annual limitation of $2,000 annually and in her small business she looks at this every year when reevaluating the cost of insurance paid for employees. What do you see these requirements doing to the cost of health care.

Mr. Thomas answered that under statutes and regulations of HHS, essential benefits have expanded to require coverages beyond that which might otherwise today be what people might choose, especially small businesses, trying to be efficient and cost-effective. HHS has issued

vast regulations trying to help people understand what these benefits are. Those benefits are not necessarily available today in every policy sold in this state. Generally speaking, if more benefits are added on, the cost for those benefits will go up. What we don't know is whether some efficiencies built into this new notion will generate savings and, if so, how do you net savings versus additional cost. His real answer was, "I don't know, predicting the future is tough." He understood her point about adding benefits and a person can today buy policies to fit their individual needs.

Scott Leavitt, Idaho Association of Health Underwriters (IAHU), said they favor a state exchange to allow for variations and innovations to accommodate specific needs of Idahoans, customized and timely consumer protections, patient advocacy and better customer service. A state exchange would ensure that state officials have complete control over associated spending, can make responsible choices about what best suits the state, and control as to which carriers will provide plans. A state exchange can include licensed agents to enroll consumers and create requirements that need to be met to sell in the exchange. A state exchange should assure a competitive marketplace both inside and outside the exchange to avoid adverse selection within the exchange. Idaho should avoid a federal exchange.

Pharmaceutical Research and Manufacturers of America (PhRMA) submitted written testimony to the task force, but did not testify in person. This information is on LSO's website at: http://legislature.idaho.gov/sessioninfo/2011/interim/healthcare1004_phrma.pdf

Several other groups submitted written testimony to the task force members.

The task force discussed future meetings, agreeing that several will be scheduled prior to session in January.

The meeting was adjourned at 3:05 p.m.