MINUTES
(Approved by the Task Force)

Health Care Task Force
December 14, 2011
Capitol Building, Boise Idaho
East Wing, Room 42

In attendance were Co-chairs Representative Gary Collins and Senator Dean Cameron; Senators John Goedde, Patti Anne Lodge, Tim Corder, John McGee, Joyce Broadsword (a newly appointed member of this task force, to replace Senator Stegner) and Dan Schmidt; Representatives Sharon Block, Carlos Bilbao, Janice McGeachin, and John Rusche. Representatives Fred Wood and Elaine Smith were absent and excused. Legislative Services Office staff members present were Ryan Bush, Matt Ellsworth and Charmi Arregui.

Others present at the meeting included Representative Phylis King; Representative Sue Chew; Senator Shawn Keough; Steve Millard, Idaho Hospital Association; Benjamin Davenport, Risch Pisca PLLC; Woody Richards, Blue Cross of Idaho; Heidi Low, American Cancer Society/Cancer Action Network (ACS/CAN); Susie Pouliot, Idaho Medical Association (IMA); John Watts and Elizabeth Criner, Veritas Advisors LLP; Director Bill Deal and Elwood Kleaver, Department of Insurance; Marnie Packard, PacificSource; Leslie Clement, Dave Taylor, Cathy Libby and Jodi Osborn, Idaho Department of Health and Welfare; Lyn Darrington, Regence BlueShield of Idaho; Rochelle Kubinski, Business Psychology Associates; Joie McGarvin, America's Health Insurance Plans; Dennis Tanikuni, Idaho Farm Bureau; Toni Lawson, Idaho Hospital Association (IHA); Jared Tatro, Office of Performance Evaluations (OPE); Mike Berlin, Idaho Alzheimer's Planning Group (IAPG); Dr. Sarah Toevs, Center for Study of Aging; Heather Smith and Bill Hoffman, Idaho Main Street Alliance; Dr. Robert Sutton, Dr. Brandon Isaacs, LeAnn Hunter, Tanner Gronowski and Suzanne Frederick, Pacific Northwest University of Health Sciences (PNWU); Aaron White, International Brotherhood of Electrical Workers; Jayson Ronk, Idaho Association of Commerce and Industry (IACI); Colby Cameron, Sullivan, Reberger and Eiguren; Molly Prengaman; Kurt Stembridge, GlaxoSmithKline; Julia Robinson, Family Medicine Residency; Cheryl Kleinbart; Brent Olmstead, Magellan Health Services; Jane Wittmeyer, Wittmeyer and Associates; Bill Roden, Delta Dental of Idaho; John Eaton, Idaho Association of Realtors; Kathie Garrett, Advocates for Addiction Counseling and Treatment (AACT); Rick Gonzalez; Molly Steckel, Idaho Medical Association (IMA), American Cancer Society (ACS), Cancer Action Network (CAN); Sarah Fuhriman, Roden Law Office; Denise Chuckovich, Idaho Primary Care Association (IPCA); Raymond Pitera, Meridian Health Plan; Dr. Ted Epperly, Director, Family Medicine Residency of Idaho; and Lee Flinn, American Association of Retired Persons (AARP).

The meeting was called to order at 9:03 by **Co-chair Representative Collins**; he welcomed everyone and called for a motion on the November 17, 2011 minutes. **Senator Schmidt moved**

that the November 17, 2011 minutes be approved, seconded by Senator Broadsword and the motion passed unanimously by voice vote.

The first presenter was **Director Bill Deal**, Department of Insurance (DOI), who updated the task force on an Idaho health insurance exchange and discussion of proposed legislation. **Director Deal** shared that stakeholder meetings about a health exchange had recently been held in which DOI participated throughout the southeastern and western part of the state. **Director Deal** addressed draft legislation RS20776 which is available on LSO's website at: www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1214_tpa.pdf

Director Deal said that when DOI prepares draft legislation, it is then submitted to the Division of Financial Management (DFM) to get approval to move forward, adding that draft RS20776 had gotten DFM's approval. Draft RS20776 has to do with third-party administrators and self-funded programs. Currently, with any self-funded plan, the third-party administrator must provide DOI with an audited financial statement. Some third-party administrators have a small number of clients, so RS20776 would give them an opportunity for choice. Instead of an audited financial statement, DOI would accept a financial statement certified by an accountant and that third-party administrator then provides DOI with a bond. An audited financial statement can be expensive for small employers, creating a hardship burden. DOI thought RS20776 would be a balanced approach to still review the financial solvency of a self-funded plan and the third-party administrator (TPA).

Representative Rusche asked how many of these small TPAs there are and what the history is on their solvency and their ability to stay in business over the last ten years. **Director Deal** answered that he didn't have the exact number, but they were few in number; he offered to get that information. He said that DOI was very careful, since legislation was passed giving DOI authority over self-funded plans. He said DOI is being proactive in reviewing financial statements. **Representative Rusche** commented that in his area there were several TPAs that folded and providers were left "holding the bag" for the cost of care, encouraging DOI to remain vigilant. **Director Deal** agreed that is a huge concern and gave assurance that DOI is being very proactive by annually reviewing financial statements.

Senator Schmidt said that since financial auditing tasks would be shifted to DOI for these small businesses, he asked how much work that would entail by DOI and the personnel skill costs. **Director Deal** answered that there are two types of financial statements: (1) an audited financial statement, and (2) a certified statement, which is different. Both come from a private CPA or accountant, submitted to DOI, and 3 DOI staff members deal with examinations. Additional burden has been placed on these 3 staff members since this law was passed but were doing fine. This would not create an additional burden. RS20776 is an idea that small TPAs wouldn't have to pay the fee for the audit which could cost $10,000 to $12,000, thus helping small businesses.

Senator Broadsword asked about "home state" and did that mean that the business would not only be licensed in Idaho but also would reside in Idaho and would DOI require state tax forms to

prove residency. **Director Deal** answered that with regard to "home state," if a TPA is going to be administering a self-funded program in Idaho, the TPA must be licensed and meet requirements in statute.

Representative Collins asked how many TPAs were functioning actively in the state and **Director Deal** agreed to get that information.

Director Deal next discussed draft legislation RS20857 which has to do with rate administration for health insurance companies and is available on LSO's website at: www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1214_rates.pdf

Director Deal gave background information saying that in July Health and Human Services (HHS) sent out a questionnaire as to the type of statute rules that Idaho and all other states had in administration of health insurance rates, particularly if there was an excessive rate increase of over 10%. DOI was surprised when HHS came back with the decision that Idaho did not meet criteria for rate review, that being a big issue for DOI and also to domestic insurance companies. DOI had meetings with insurance companies and decided that changes needed to be made through a memorandum of understanding (MOU). This was sent back to HHS to explain what DOI would do. This passed muster, and on September 30, 2011, HHS rescinded their decision and allowed the state of Idaho and DOI to retain its regulatory authority in the rate-making process. Draft RS20857 adds general standards and rulemaking authority for DOI and removes confusion over proprietary issues and provides that DOI can provide public disclosure of rates, guided by Idaho laws. Domestic insurance companies worked with DOI on this draft and there was no opposition.

Representative Rusche inquired if this draft would require the rate review to occur prior to sale. **Director Deal** answered "yes" and said that filings for policy provisions, as well as rate increases, must be made to DOI. Rate increases are submitted to a CPA, are reviewed by DOI and the CPA, and there is funding for an actuary.

Representative McGeachin expressed interest to learn how this will work and said that her company had received a rate increase that she considered to be excessive and asked how "excessive" is determined and what authority DOI has to correct that. **Director Deal** responded that "excessive, inadequate or unfairly discriminatory rates" is a definition DOI will define in rule, adding that HHS criteria states that an increase over 10% is excessive. **Representative McGeachin** wanted to know what happens once a determination is made about a rate being excessive. **Director Deal** explained that when DOI does not approve a rate, the company is asked to come to DOI to explain an increase; if statute and rule requirements are met, then that is the rate going forward.

Senator Goedde said he was concerned about the "unfairly discriminatory" language in the draft; he has heard that younger people will end up paying premiums for older people, and he asked if DOI was looking at that as being "unfairly discriminatory." **Director Deal** answered

that it is true that younger people will have a significant rate increase and the older people much less, this being a real problem going forward. Even though rates are high, Idaho has some of the lowest small group rates in the nation. DOI is staffing up the rates performance department, aware that this will be a big job.

Senator Corder said he was also worried about how small companies would fit in that are now being allowed to compete in the exchange in the market with unaudited credentials. He believes that the words "excessive, inadequate or unfairly discriminatory" in legislation could be opening doors for litigation and is anxious to see how this will be resolved in rule, since this could have statewide implications. **Director Deal** said that those terms have been used with regard to property and casualty rates forever, so he thinks that DOI has a good, solid basis of what those words mean, believing this will not be that difficult to deal with. **Senator Corder** wondered if there would be some element that will change now because of competition and small companies finding a competitive disadvantage.

Senator Cameron clarified that in practice the language in draft RS20857 has been there previously for insurance companies and that the federal government said that Idaho statute was not clear enough. The benefit of placing this in statute and in this draft is that DOI gets to define what these terms mean. The threat earlier in the year was that if statute was not changed, then the federal government would come in, regulate and define terms. **Director Deal** affirmed this was correct, adding that this draft was putting rate regulation with DOI in Idaho, rather than with the federal government in Washington, D. C.

Representative Rusche further clarified that the 10% is a threshold for examination; people shouldn't believe that a rate increase must be limited to below 10%. The methodology would be examined and the rate would be justified, but this would be a pool rate, not individual. **Director Deal** said that was correct, adding that with regard to the base rate, which is what is being talked about with rate increases, there has not been a rate increase over 10% this year.

Director Deal next referred to draft legislation relating to the health insurance exchange, available on LSO's website at:
www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1214_draft.pdf

The Idaho Health Care Council established by **Governor Otter** worked on this draft and was further defined by another group. **Director Deal** said the draft is a cross-section of thoughts and innumerable recommendations received from interested parties. This draft was completed on December 9, 2011, and is a work in progress as it moves forward through the legislative process. DOI wants a bill that everyone who is involved in the exchange can agree on. **Director Deal** went through the exchange draft, pointing out changes and clarifications.

Representative Rusche said the role of "navigator" on page 3, line 22 was not clear to him, particularly since there has been concern and confusion about the "navigator's" role. He wondered about an inherent conflict of interest if a "navigator/producer" is the same person or

within the same company. He asked how a possible conflict of interest could be prevented and is a failure to articulate that navigators cannot be producers consistent with federal law. **Director Deal** answered that there is a very clear definition what a producer is in Idaho Code, so DOI could draw a line saying that if someone was going to solicit, advise, and then sell a policy, that is a producer, an agent. A navigator means a person who assists with eligibility, enrollment, program specifications and public education activities related to the exchange. The process is going to be new and perhaps difficult, including application, qualification and choice of a plan. **Director Deal** pointed out that a navigator would be registered and would be required to participate in continuing education. A navigator cannot receive compensation from an insurance company, and, by rule, the navigator will be compensated through a grant from the exchange based on criteria. DOI is trying to clarify that the differential is that if someone is a licensed producer, then compensation can result. The navigator compensation issue, he said, is an ongoing, big issue. **Representative Rusche** commented that he had received feedback that the Governor's Health Care Council seemed to have fairly heavy representation within the insurance industry, especially considering the backgrounds of the Directors of DHW and DOI, and asked if that Council was light on purchaser/citizen input. **Director Deal** agreed that was a good question, and said that we need to take a look at what the board is going to do. He believes that an administrative board will have to know a lot about IT and have management experience. Approving companies by looking at financial stability, market conduct and other issues still falls to DOI. Secondly, plans and rates will be submitted to DOI and anything having to do with the product. Anything having to do with the distribution system would be done through the board.

Representative McGeachin said that when she visualizes an exchange, she sees it as something a consumer can access, looking for information, shopping for a product amongst a plethora available. When talking about a true, free-market exchange, that would mean to her any type of product that could serve to benefit or assist that individual with their specific needs. Her concern was the language on page 2, line 25 (9) (a) through line 21 on page 3 and what a health benefit plan does not include. Where does this idea come from to define what a health benefit plan is and then lengthily pointing out what it is not; she asked what is the purpose of putting it there. **Director Deal** answered that this language is needed to first describe what a health plan is since it must provide essential benefits. He said it was necessary to define what a health benefit plan does not include because it helps to further define specifically what a plan is. **Representative McGeachin** expressed concern about a plan wanting to restrict other products that might be beneficial to a consumer or to locate and buy products through the exchange. **Director Deal** reiterated that in order to be a qualified health plan, criteria of the Affordable Care Act must be met. He used Aflac as an example of a product that will be offered outside an exchange; Aflac wants it that way, as do other companies who do not want to be in an exchange, for many reasons. If a company doesn't have a product that fits the definition of the plan, DOI was very careful in this draft legislation to distinguish which plans could not be part of the exchange.

Representative Bilbao said that many constituents in senior centers and nursing homes in his district do not quickly comprehend what is happening with regard to the insurance exchange. His question was whether a navigator could work in all areas of a district or be limited to a town.

Director Deal clarified that people in assisted living centers are primarily age 65 and over, so the exchange only covers people through age 64. As far as a navigator's territory, that is an issue being worked on, and DOI is working with other states with the same issues.

Representative Collins asked if a navigator would work with the under-age market and **Director Deal** answered that was a good assumption, this being the idea of what a navigator is, an advisor.

The next presenters included a panel of four from Pacific Northwest University of Health Sciences (PNWU) who gave an update on Idaho students receiving graduate medical education at PNWU. **Dr. Robert Sutton**, Chief Academic Officer, spoke first and said he got his Ph.D. from the University of Idaho and taught in Twin Falls. PNWU acepted its first class in the fall of 2008 and is graduating the first class in May 2012. PNWU is the first new medical school in the Pacific Northwest in sixty years. A packet of materials from PNWU is available in the Legislative Services Office. For the first two years, students study in Yakima, Washington and the last two years students practice in their own local communities. PNWU has looked at expanding development with **Dr. Ted Epperly** here in Boise in a collaborative way. PNWU wants to accommodate Idaho students. **Dr. Epperly** wanted to impress to the task force that students stay where they practice. Whatever resources are available, money or policy, are needed at the end of a student's education, as students go into residency. Developing further residencies or developing loan forgiveness is the payoff that gets physicians to stay instate.

LeAnn Hunter said she recruits students to PNWU to join the program to become medical students and who want to return to their communities to practice and serve. At the end of a student's second year, a student selects the area to do third-year rotations, currently choosing from sixteen sites in the Pacific Northwest, two in Idaho, Boise and Blackfoot. For the first time, she said there will not be enough residencies available in Idaho for every student who wants to come back, so opportunities in Idaho need to be expanded. PNWU received over 2,300 applications for 75 student spots. Nationally, 78 students from Idaho applied to medical programs; 58 applied to PNWU, and 12 were accepted.

Representative Rusche asked if insufficient residencies in the Pacific Northwest was due to low population levels or insufficient funding to develop staff residency programs what is the basis for that, and how does that compare with the nation as a whole? **Dr. Sutton** answered that there is a significant shortage of residency programs due to a poor infrastructure in Idaho and among hospitals for building residencies. This comes down to where the federal government is, as well as a lack of money and infrastructure. There are opportunities in Idaho to develop additional residencies.

Senator Goedde asked for an explanation on the difference between what PNWU offers and the University of Washington. **Dr. Isaacs** said that he was a D.O., a Doctor of Osteopathy Medicine, and a graduate of BSU, and attended the University of Idaho. **Dr. Isaacs** went to medical school and practiced his residency outside the state, but returned to Idaho ten years later. He explained

that Doctors of Osteopathy are taught a different concept, i.e. a holistic approach to care for patients, the biggest difference between a D.O. and an M.D. **Dr. Isaacs** is an M.D./D.O. by training. He said that Idaho is tied for dead last in physicians per capita and a poor job is being done meeting the needs of communities. In order to overcome that, people at the undergraduate medical education level have recognized the Northwest's lack of physicians, and PNWU was built under that premise. Ninety-three percent of PNWU's students are from the Northwest. These students are being trained locally, to stay local and to practice local where the need is. PNWU is not the only medical school doing this, and over the next 2-3 years, this region will get approximately 300 more medical students looking for residencies in which to practice. PNWU does not have the graduate medical education to support those medical students. Seventy percent of students stay where they do their residencies. Family medicine is not the only weakness in Idaho; Idaho needs more physicians in every field, and negotiations have begun to expand in other facilities, using the osteopathic model to develop those residencies. There might be legislative ways to recoup the investment being made currently in undergraduate medical education, and **Dr. Isaacs** said he discovered a model that might be applicable. **Dr. Isaacs** said he had shared this information with **Representative Fred Wood**, who was absent and excused from this meeting. Alabama has developed an extremely cost-effective way to help assist with education of graduate medical education, i.e. residencies, as well as undergraduate medical education, and Alabama is getting 100% return on investment (ROI).

Tanner Gronowski introduced himself and is a third-year medical student at PNWU, having grown up in Eagle, and then attended and graduated from St. Martins University, Olympia, Washington on an academic and athletic scholarship. His top three choices for medical school were in the Pacific Northwest, and he chose PNWU because the school "blew him away because it felt so right." He referred to PNWU as a "giant home with a family where I was welcomed in." He thinks PNWU is incredible and said that the faculty, administration, and staff are phenomenal and are there to prepare good, competent physicians. **Mr. Gronowski** was very excited to find out that his third and fourth-year rotations would be in Boise. He is looking at residencies outside the Pacific Northwest to do his training, but ultimately his goal is to come back to Idaho to practice.

Senator Goedde asked the difference in tuition between PNWU and a similar program at the University of Washington (UW), and the answer was that the UW has a very prestigious program with a large research base. **Mr. Gronowski** has a friend attending medical school at UW and he pointed out that UW is more competitive; PNWU teaches a team concept where students share, encourage, and support each other. Tuition annually at PNWU is $42,000 and a subsidized tuition at UW is $20,000, and out-of-state tuition is twice that ($40,000)**.**

Representative Block asked where else **Mr. Gronowski** would be doing rotations and what criteria will determine where **Mr. Gronowski** will eventually practice. **Mr. Gronowski** said his current rotations were in the Treasure Valley in Boise, Nampa, Caldwell, and Mountain Home. He said residencies must meet certain criteria, so a student will come out of almost any residency as a competent physician. Location to him, personally, is important, and he does want to practice

in the Pacific Northwest. He added that loan forgiveness would be attractive to any medical school graduate.

Senator Lodge asked for clarification about tuition, asking also about living costs which are less in Yakima than in the Portland or Seattle areas. **Ms. Hunter** said she does financial aid for PNWU and said that the annual standard budget is about $70,000 and the average loan debt last year was about $60,000 annually, totaling $240,000 for the four-year program. Loan forgiveness programs can be at a state level, through service (National Health Service Corps) or through the military. There is a huge investment in the career of a physician, and students are looking for help at the end from employers, from the federal government or from their state, trying to reduce that debt to go into a practice. **Senator Lodge** mentioned the rural physician incentive fund through the Idaho State Board of Education. A rural physician may receive $50,000 over a five-year period to practice in an area where a physician shortage exists. (Section 33-3725, Idaho Code)

Senator Goedde asked if Idaho ought to be looking at more residency seats, and if that was what was being suggested. **Dr. Sutton** answered that he would love for Idaho to invest in PNWU but added that would not be a good outcome. He said that Idaho needs to invest in residencies and invest in where graduates go to practice. To improve the workforce in Idaho, efforts need to be improved on increasing residency programs and encouraging hospitals and communities to offer loan forgiveness. He said if a community would offer $25,000 yearly for 4 years, that community would probably have that new physician forever. **Senator Goedde** said that Coeur d'Alene was working on a family practice residency program. This is going to involve a major commitment in local dollars to make that work, suggesting that perhaps money may have to come from communities rather than the state. **Dr. Sutton** agreed and said that family practice residency is expensive and that when a community needs physicians, they need to be creative to attract new physicians.

Representative Rusche commented that there are financial limitations from the state, and he asked what could be done by leadership or through organization to increase residency slots in Idaho or stimulate similar development in the state to expand production of primary care physicians. **Dr. Ted Epperly**, Director, Family Medicine Residency of Idaho, answered that everyone in Idaho is part of the solution and the federal government or the state should not be looked at singularly for a solution, since he believes this is a community problem. What might work would be some sort of matching program between potentially the state and communities to help develop residency programs. Until there are adequate residency programs, the workforce will not be built here. There are no graduate medical education programs after medical school to import quality students and then keep them in the state to practice. The groundwork must start with residency programs in multiple communities since there are currently 300 medical students in the Pacific Northwest wanting a place to practice residencies. We must first attract them in order to keep them. The state needs to partner both with local communities and industries to help invest in residencies to arrive at a sustainable solution over time. Family medicine is clearly

a backbone for care in Idaho, but we must also invest in general surgery, pediatrics, internal medicine, and psychiatry to grow that kind of primary care workforce to better serve the state.

Representative Rusche said that financial support was mentioned, asking if there was facilitation to help communities develop that and would that be an appropriate role for the state in manpower development. **Dr. Sutton** said that certain hospitals are financially viable to do family residencies and that residencies pay for themselves, except for startup costs, which are significant. Ongoing costs are able to be paid, and in certain environments this can happen, so it isn't as hopeless as it may sound.

The next presenter, **Leslie Clement**, introduced **Cathy Libby**, Project Manager, Medicaid System Support Unit, Department of Health and Welfare. **Ms. Libby** said she had the challenging opportunity to lead the Medicaid Management Information System (MMIS) certification effort. She has also worked on the design, development and implementation of the new MMIS products for more than four years. **Ms. Libby**'s PowerPoint presentation is on LSO's website at:
legislature.idaho.gov/sessioninfo/2011/interim/healthcare1214_mmis.pdf

Ms. Libby said that the MMIS certification process is controlled by federal partners, the Centers for Medicare and Medicaid Services (CMS) and that they took the entire Medicaid enterprise and broken it into twenty business areas. Checklists were developed for each business area, and within each certification checklist are multiple system review criteria being looked at to determine whether or not the Medicaid system meets the federal and state requirements. Sixteen checklists applied to Idaho for MMIS certification and data was collected to verify all MMIS functionality. She showed the task force several incredibly thick binders which held the checklists for Idaho's MMIS.

Ms. Libby said that preparation activities began soon after going live. The pharmacy system in February 2010 and the Molina base MMIS went live in June 2010, and the decision support system data warehouse went live in mid-July. Certification activities led by state staff were prepared for the CMS site visit, and site visit roles and responsibilities were defined. The schedule of site visit activities was finalized, and the CMS site visit occurred December 5-9, 2011. The CMS team included 9 reviewers, and state staff delivered presentations to demonstrate MMIS functionality. CMS staff reviewed data to verify system functionality and eight additional ad hoc meetings were conducted. Over 100 action items were produced, tracked and resolved all before CMS left. **Ms. Libby** expressed her appreciation for her team, all their hard work and the outcome of the site visit.

A summary of the CMS exit conference can be found in **Ms. Libby**'s presentation which is on LSO's website at:
legislature.idaho.gov/sessioninfo/2011/interim/healthcare1214_mmis.pdf

Senator Lodge expressed amazement at the amount of work in this certification process and thanked **Ms. Libby** and her team for this huge work effort.

Representative Rusche said he echoed **Senator Lodge**'s comments and asked if **Ms. Libby** had been through a certification process previously. **Ms. Libby** answered she had not, adding that it was a challenging and interesting effort. **Representative Rusche** said he had been through several system and product certifications and said that this was a really good process; his experience has been that the exit interview usually tells the story, which he believes is very optimistic.

Senator Goedde asked how many providers had refused to accept Medicaid patients since Molina came on board and **Ms. Libby** did not have that number. She said she knew that some providers had stopped billing the Medicaid system, but that would happen on any occasion; anything directly related to the MMIS implementation, she was not aware of. **Ms. Libby** said there are reasons why providers terminate, and there is a voluntary termination reason, but associating that directly to the change in the MMIS products and vendors, she didn't believe could be tracked to that degree.

Senator Schmidt inquired about a positive observation by the CMS team, that being the average time to enroll a participant with a primary care provider (3.5 days) which was highlighted as very efficient. He wondered if that meant "to be seen or to have them enrolled on a provider list." **Ms. Libby** said that relates to actually receiving information from the eligibility system and attaching that participant to a primary care provider. It doesn't mean that the person has accessed care with the provider within 3.5 days. **Senator Schmidt** said it seems with that number being low, there are a number of providers in the system that provide for that efficiency. **Ms. Libby** answered that there is a good provider network, particularly primary care case management entities.

Director Richard Armstrong, Department of Health and Welfare, presented next and his PowerPoint is available on LSO's website at:
legislature.idaho.gov/sessioninfo/2011/interim/healthcare1214_budget.pdf

Director Armstrong was asked to discuss budget issues, and he said that poverty is the primary driver for many public assistance programs. In 2006, Idaho had a lower poverty rate than the national rate. Idaho was 12.8%, while nationally 13.3% lived below poverty. In 2010, Idaho poverty estimates exceeded national averages. An estimated 15.8% of Idaho citizens lived below poverty, and 15.3% nationally were below poverty. The growth rate for some assistance programs is slowing, but workload remains high. In 2008, $100.2 million was being distributed in food stamps with 95,433 participants, and that grew 31% between 2008 and 2009 and jumped to 43%, leading the nation during that period in rate of growth. It slowed a bit to 25% between 2010 and 2011, and the very good news is that for the last 3 months, it has been at 5%. Idaho, historically, had been the one state identified as having more people eligible **for** benefits but not

in benefits, so the recession brought a compression, and the rate of growth outstripped most other states. There has been a significant flattening of that growth rate.

Director Armstrong said that the workload remains at its highest ever. Looking at the work involved, all welfare programs must be recertified every six months, so when application volumes came in, a base was being built that had to be managed. In 2005 there were about 5,000 recertifications monthly, and now there are over 13,000 recertifications that must be handled. What that means is that there are 64,000 tasks that have to be managed on a monthly basis. In building a new process, there are extremely good management metrics to determine exactly what is happening month-to-month. Today about 29,000 phone calls are handled monthly regarding applications and recertifications. The re-engineeering process has been very positive from a production standpoint. In 2005 each worker handled 187 cases and today each worker handles 555 cases. **Director Armstrong** pointed out that it is rare to see that kind of productivity gain in a process. Not only is Idaho's food stamp program performance more efficient, the annual administrative costs for each food stamp household was $218 in FFY 2010. By comparison, Utah was $468, Oregon was $372, and Montana $385. Estimated costs per 100,000 food stamp households:

1. Idaho $21.8 million
2. Utah $46.8 million
3. Oregon $37.2 million
4. Montana $38.5 million

Director Armstrong said that Idaho right now is running 99.01% in timeliness in all food stamp applications processed within federal guidelines, and that puts Idaho second in the entire nation. All of the food is 100% paid for by the feds and 50% of administration is paid by the state. There is a budget item coming up in the 2013 budget having to do with a multi-day issuance of food, a proposal crafted by DHW following grocer requests. Transition to multi-day payments has an initial one-time cost of $440,000. The proposal is for DHW to contribute $120,000 + grocers $100,000 + feds $220,000 = $440,000. There is good reason to look at this due to the impact on customers in stores. Ongoing annual costs amount to $220,000 since there is more complexity in a multi-day issuance situation than there is in a single-day issuance.

Director Armstrong shared very good news on Medicaid, that enrollment has slowed and costs are down, for the first time in six years. The trend is that Medicaid enrollment increased by 9.5% between 2009 and 2010, then dropped to 6.4%. Through FY 2012 that increase has been less than 1%, another correlation to the reduction on the food stamp side. There will also be an early warning system start to show the same trend on the Medicaid enrollment side. The majority (72%) of Medicaid enrollees are children, and that has always been the case. The trustee and benefit costs have declined due to House Bill 260 and the fact that DHW's forecast for a reduction of about $90 million ($35 million from state funds) is on track and DHW is accomplishing those savings. The outcome of all of these actions passed through the Legislature are now yielding the forecasted savings. **Director Armstrong** said that for the future, DHW is looking at how to use managed care opportunities and other ideas to make Medicaid sustainable.

With regard to the Southwest Idaho Treatment Center (SWITC) (formerly Idaho State School and Hospital), **Director Armstrong** said that SWITC was once surrounded by farmland but is now in Nampa city limits. Land value has greatly increased. ISSH once housed 1000 residents and today SWITC has 47. Smaller disability facilities may be able to manage people closer to their homes, and patients always do better when closer to family. Residents of SWITC continue to discharge into community settings, reducing need for buildings and surrounding acreage. SWITC land and buildings are rented to the Department of Correction, Juvenile Corrections, JOB Corps and City of Nampa. SWITC is a state asset, and its future must be carefully planned. A company has been secured to do a master plan for SWITC and a land analysis, so in March 2012 that should be complete, outlining multiple options, and various stakeholders will be consulted to develop this plan.

Director Armstrong said that a barrier in the road completely blocks all access from the west of I-84 to go onto Ridgecrest Road to get to SWITC. This is a major public safety issue recognized by the city of Nampa and DHW is working with the city of Nampa to realign Ridgecrest Road to intersect with the light at Franklin. Spending authority will be in the budget and, fortunately for the state of Idaho and DHW, there is a piece of land in that intersection rebuild from which the state of Idaho needed to drain surface water into a holding pond. That land was sold and that money has been held in trust to realign the road which will enhance the value of the SWITC property dramatically. The city of Nampa has agreed to do the engineering and construction, and if the project overruns, DHW's cost is limited to the amount of money held in trust, and the city of Nampa will pay any overrun amount. **Director Armstrong** said that the master plan contract requires multiple options for state consideration and that DHW will seek legislative approval for road rerouting to ensure good safety access to the SWITC campus by fire and first responders.

Senator Lodge asked what the negotiations were currently with the city of Nampa about the two golf courses. **Director Armstrong** said there were actually three golf courses, the two eighteen hole courses and one junior nine-hole course in the middle. He said the leases have been extended until 2014 until the Ridgecrest lease comes up, so that a single-lease arrangement can be dealt with on all of the property. The city of Nampa did survey the actual perimeter of the golf courses which means that any acreage not part of the golf courses would be available for use by the state of Idaho in the master plan. There is no obligation beyond 2014 with the current leases.

Senator Lodge inquired about the multi-day food stamp issuance and the ongoing annual cost of $220,000 or more, wondering if this would be forever or just for a certain period of time. **Director Armstrong** answered that those costs will be ongoing into the future because it has to do with how to maintain the certification and the issuance of cards. Part of the cost is for fraud and abuse features to be built in, such as cards that include a name. Equipment needs to be purchased as well as ongoing maintenance costs, and it must be very clear as to when food stamp cards will be loaded. Good communication is necessary for grocers so that purchases are not attempted on the wrong dates, as well as to avoid confusion to recipients of the program. **Senator Lodge** asked about the $660,000 up-front costs incurred, much of that having to do with

credit card company requirements to make any change at all made to the food stamp cards. She asked if that $440,000 "rebate" could be used for something like nutritional education of what kinds of food people should buy. **Director Armstrong** said that the initial cost of $440,000 is paid for by the feds, so that is isolated. The $100,000 from the grocers is definitely for this project, so that leaves $120,000 which was bonus money paid to DHW (not guaranteed and a one-time event) for performance around distributing food. That money has some constraints and is supposed to go back into the food stamp program, so it would not be transportable to another agency. As far as educating people about good nutrition, DHW does have programs to do this, although it is frustrating because many young mothers prefer convenience to good nutrition. Federal guidelines must be followed, which is also frustrating; the state of New York tried to deny payment for sugar-drinks and this could not be done. USDA sees the food stamp program basically as wholesale or product distribution from the agricultural side of the business, and not as a nutritional program. Therefore, DHW has restrictions on what can be done in this area.

Representative Bilbao said that the media reports indicate that the feds are going after welfare fraud, asking if any preliminary instructions had been received by DHW regarding this new program the feds will implement. **Director Armstrong** answered that there have been a number of conversations with various federal agencies dealing with fraud. The primary focus is on institutional fraud where there is actually collusion at the retail level with a cardholder. DHW has done some data mining and evidence of institutional fraud has not been found in Idaho, as has been found in other states. The only concern has been in some very small retail outlets where a clerk may know the cardholder and a deal is struck. When certain characteristics show up in a pattern, then DHW pursues those situations with the fraud unit.

Representative McGeachin commented on budgetary items in **Director Armstrong**'s presentation, and she asked about plans that DHW needs to implement to bring the Medicaid program up to readiness to meet federal law. She asked if that is going to be a specific item budget request. **Director Armstrong** said that Medicaid readiness is a requirement and Medicaid is required to meet federal standards, so without regard to composition of the insurance exchange, Medicaid has to be the front door for eligibility and screening, in real time, online, 24/7. DHW is in the final stages of preparing an advanced planning document ready to go to the feds in December 2011 which is how administrative dollars are established for Medicaid, by and large a 90 (feds)/10 (state) reimbursement. That 10% will be an obligation of the state of Idaho to pay for Medicaid readiness, and **Director Armstrong** said that this is massive and will be very expensive, possibly in the $30 million range.

Representative McGeachin asked for clarification about whether some requirements are part of the new PPACA (Patient Protection Affordable Care Act) Law or are the requirements coming from CMS not necessarily related to the Federal Health Care Law. **Director Armstrong** replied that the PPACA included a portion that is for Medicaid expansion for adults without children in the household, previously not a part of Medicaid. DHW estimates that number to be about 100,000 individuals becoming eligible starting January 2014, but it will take time to enter those individuals into the system. Depending on the outcome of the Supreme Court ruling, if there is

severability, then Medicaid expansion probably will go ahead. Globally, it is part of that bill but whether or not they stay together is not known. As a Medicaid administrator, Medicaid must be in compliance with that expansion and that delivery method. This requirement will benefit other welfare programs as well because there is only one eligibility system for all programs, unlike some states that have multiple eligibility systems.

Representative Rusche asked about the managed care development brought forward through House Bill 260 last year, and he asked **Director Armstrong** to bring the task force up to date on where DHW was with managed mental health for Medicaid that was under development. He also asked about the timeline for further managed care development, particularly looking at previous interactions with vendors and contractors about contract development and vendor oversight for these managed care contracts. **Director Armstrong** answered that the RFP (request for proposal) development is underway and it will be around February 2012 that DHW would be able to issue that mental health RFP. DHW will include in that, as is required, that the network must be displayed, how the network will be managed, so the plan must be developed and presented up front as far as the range and scope of the network, the ability to guarantee access, and meeting benefit requirements of the state plan. It would be DHW's intent to apply all of the management processes, deployed through MMIS with any new vendor agreement to ensure accountability, especially with regard to behavioral health since Idaho is an under-served state. In some communities, it will take a creative approach to get services delivered. **Representative Rusche** said that since managed care contracting is new, it would be wise that certain best practices would ensure expertise for contract development and standards of oversight to prevent lack of data a year later or to prevent accurate projections being made on utilization. **Director Armstrong** said that he agreed wholeheartedly; DHW thought originally that this could be done in December 2011, but it is taking more time. Other states have been consulted and preliminary actuary studies done, and a report will be given during session. DHW knows that other consulting assistance needs to be secured, since this is such a big deal and it must be done correctly.

Representative Block said she didn't understand about the 90/10 match and she asked what that match will apply to since there is only one system. **Director Armstrong** replied that the Affordable Care Act and the insurance exchange have multiple parts and are not one thing, but have multiple pieces. Medicaid has an obligation to handle the expansion of Medicaid as well as the way in which the application is processed. It must be electronic, web-based, web-enabled, and adjudicated in real time. Let's assume there is an Idaho exchange marketplace and someone coming in for the first time bought a product, lost their job and now is eligible to come back to Medicaid. The crosswalk must be built over and back so that a person can do an abbreviated application later, since law states that if information is taken once, information can't be asked for over and over again. This means, he said, that DHW will maintain a member record for all 1.6 million Idahoans, and the system must be that robust. Medicaid has that task which will be the same whether there is a federal or state exchange, or a hybrid. Under CMS rules, the feds will pay 90% of the development costs for eligibility processes and application processes. DHW has developed a plan and will submit that plan which says that this is what the Medicaid side of the

business will be for eligibility and what that will cost; that plan must be approved and 90% of those costs can be drawn down as accrued over the next year, since this must be ready to be certified by January 2013. Because there is not much time, costs are going to be higher due to scarce resources and having to do this in such a short period of time. DHW understands Medicaid eligibility well and how to automate it, which will go to the feds for approval. Ten percent must come from the state general fund and that would be through an appropriation request through JFAC.

The task force recessed for lunch at 11:58 and reconvened at 1:30 p.m.

The next presenter was **Raymond Pitera**, Vice President, Meridian Health Plan (MHP), a Medicaid HMO operating in three states across the country and is not based in Meridian, Idaho. He was here to explain to the task force about Medicaid managed care; he said that Meridian Health Plan began 15 years ago in one rural area of Michigan by a physician/owner, and it is now the largest Medicaid health plan in Michigan, operates in Illinois, and is the only Medicaid managed care organization in Iowa. There were 1,400 individual Medicaid members to start. MHP was unsure as to how these members would be managed and care coordinated for best quality outcomes, and nationally MHP was ranked the smallest and at the bottom. With innovative technology and growing pains, MHP has learned, and managed care today includes all Medicaid populations. Twenty percent of the Medicaid population drives about 80% of the cost, and 3% of the population drives about 45% of costs. That 3% needs complex case management. Programs in place have resulted in better health outcomes for members, and the cost curve has declined. Today, MHP does population management, and systems are in place; MHP reaches out to members telephonically and, if necessary, face-to-face with every member. Today, in Michigan, MHP has 290,000 members enrolled; that is important to understand when looking at Idaho with 230,000 Medicaid eligibles today. With the Affordable Care Act, the potential is between 60,000 and 100,000 members coming on.

Incentives are offered for healthy members to teach accountability and to care for themselves. Idaho has important decisions to make with regard to the Medicaid population, and it is important to understand there are more options than the typical HMO. Preventive care needs to be the focus, and MHP does a health risk assessment, stratifies each member and gives members personal attention based on individual need. Education is important, and MHP gives incentives to coordinate care, to redirect members from emergency rooms to an assigned patient center medical home.

MHP sees opportunities in Idaho for overall medical care. It is MHP's belief with regard to pharmacy, by realigning goals of care and with formulary and plan design, members could be redirected to a generic-based formulary that still relies on brands when necessary. This would create the greatest efficacy and outcomes in quality at the lowest cost sometimes with a decrease of around 52% to 55% off current costs. There are many programs being offered, but nothing on the same level of population management offered through MHP. Partnering with physicians and hospitals is important when working with the Medicaid program, and accessibility is number one.

Representative Rusche read through the MHP brochure (available in the Legislative Services Office) where it mentions being physician-owned and physician-managed, and he asked if MHP was a for-profit or a not-for-profit model. **Mr. Pitera** answered that MHP is a for-profit model. **Representative Rusche** inquired about MHP's existing pharmacy network and **Mr. Pitera** said that MHP had started out small and has grown considerably. A pharmacy benefit management system called MeridianRx was created. MeridianRx system has built a pharmacy network across the nation that includes about 55,000 pharmacies including some in Idaho, both chains as well as individual pharmacies.

Senator Broadsword asked about other states where MHP has a presence, and if the managed care program saves the state money or is it another way to package it. **Mr. Pitera** said that in each state, the goal is always to increase the quality of care, but it often reduces the total expenditure for Medicaid from the general fund. In each state, dollars have been saved, and in Michigan the total Medicaid population is 1.8 million members, and 1.2 million are rolled into a Medicaid managed care organization. The other 600,000 are not in Medicaid managed care. The Medicaid managed programs there have averaged savings of around $300 million annually for the last ten years. Michigan started off as a primary care case management model, and that model did not meet the state's needs for cost savings but did establish a medical home for the members. Michigan made the tough decision to move from primary care case management to managed care HMOs, and this program has done very well for the state of Michigan. There are fourteen Medicaid health plans in Michigan and 1.2 million members enrolled in Medicaid. Illinois hopes to get to mandatory enrollment in 2015 into managed care organizations such as MHP.

Co-chair Collins informed the task force that in addition to the draft legislation discussed at this meeting, there are other drafts being circulated that the task force members have not yet seen. He invited drafts to be presented to the co-chairs for consideration prior to the next meeting. **Senator Cameron** emphasized the importance of getting draft legislation to the co-chairs in writing prior to the next meeting in January, so that drafts can be on the agenda. The task force members need time prior to the meeting to look at what will then be voted upon at the January meeting.

Mr. Mike Berlin, Idaho Alzheimer's Planning Group, spoke next and said that his group was a grass roots volunteer organization whose mission is to elevate the issue of Alzheimer's disease and other dimentias and the way people are being impacted who are suffering, as well as families in Idaho. **Mr. Berlin** thanked the task force for allowing him to use this forum to make people aware of this issue, and he expressed his gratitude for **Senator Broadsword** championing this issue and for sponsoring a draft Senate Concurrent Resolution which is available on LSO's website at:
legislature.idaho.gov/sessioninfo/2011/interim/healthcare1214_scrdraft.pdf

Mr. Berlin went through this draft concurrent resolution with the task force. **Mr. Berlin** said that his group is trying to put together a statewide plan and to implement that plan. Some 26,000 Idahoans are currently diagnosed with Alzheimer's disease, and the number is projected to

double in the next 14 years, and has the potential of overwhelming the health care system. Idaho's mortality rate from Alzheimer's is higher than the national average, and the reason is that Idaho's fastest growing age segment of Idaho's population is people 85 years of age and older. Data is being collected and conferences are being held to gather and analyze data from family caregivers and health care professionals as to issues they deal with. Thirty-five other states have state plans for addressing Alzheimer's disease, and **Mr. Berlin** pointed out he was not here to ask for money. He was asking for the task force's endorsement of the draft Senate Concurrent Resolution that would be forwarded to the Legislature. His group is looking for legitimacy and credibility when grants are applied for, as well as when state agencies are approached with regard to implementation of recommendations coming from the state plan. If dollars are required to implement the state plan, directors of state agencies might be approached to put money in their budgets as a cost offset. The state plan will include options for families so that patients will not have to be institutionalized using state dollars, which is the ultimate goal of this group.

Senator McGee asked for clarification on whether the task force would vote on this concurrent resolution now or if the members would be given time for further consideration, and then vote on all legislation at a future meeting. **Co-chair Collins** said that all legislation would be voted on at the next meeting in January.

Senator Broadsword asked if **Mr. Berlin** would need to be present at the January meeting when the vote is called for on this Senate Concurrent Resolution. **Co-chair Collins** replied that it would be sufficient for **Senator Broadsword**, as sponsor, to present this at the January meeting and it would not be necessary for **Mr. Berlin** to attend.

Senator Goedde was allowed to forward his meeting notes to the members of this task force from the National Association of Insurance Legislators annual meeting in Santa Fe, New Mexico, held on October 21, 2011. **Senator Goedde** was invited to share highlights of his meeting notes with regard to health exchanges. He pointed out that he wasn't sure anyone knew at this point what is going on. Even Health and Human Services (HHS) admitted they are behind the curve, as far as time goes, to meet the federally mandated timeline. There were panel discussions and he had not heard before about the opportunity to rent a health exchange. Two states have opted to adopt the federal exchange, Louisiana and, by default, North Dakota due to failure to pass state health exchange legislation, unless a special session is called. Whatever a state does must be done this year or, by default, the exchange will fall to the federal exchange. A state could then develop its own plan or a hybrid plan, and one speaker estimated this cost will be between $20-70 million to develop an exchange. **Senator Goedde** found it interesting that any state health mandates will come at the expense of the state and there will be no money to pay for those in the exchange mechanism. He said the main cost of an exchange will be IT expenses; many said that whatever is budgeted, a state can plan to spend twice that amount. The delivery cost is a subsidy that states will have to pay; all federal funding is gone by 2015, and if a state opts for a federal exchange, there will be no further federal development money available for a state that does that. HHS will have essential health benefits ready before session in draft form but will not have been adopted. The Governor's Association suggested that states consider shared services and Delaware and Maryland are looking at this option. A federal data hub could be available for

states to use at a cost. Costs for smaller states seem to be larger than for large states. Financing options were discussed: whether you charge insurers which falls back to consumers, service fees to consumers of small business, membership fees, paying for the exchange through navigator license fees, qualified health plan certification fees, expanding general funds to pay for an exchange, or selling advertising on the website. Perhaps some combination of these will end up financing what an exchange looks like. There was a suggestion that states start assessing fees in 2014 to build up an operating reserve for 2015 when it becomes the sole responsibility of states. **Senator Goedde** expressed his appreciation at being able to attend this national annual meeting and to present information on health exchanges to this task force.

Representative Rusche commented about the Oklahoma rental for $20,000 monthly or $250,000 annually, asking if this seemed realistic when it's going to cost even a small state $20 million to build an exchange and are estimating $10 per member. **Senator Goedde** said he found that number to be amazing and was certainly way under what the feds had expected. He pointed out that health exchanges available to be rented do comply with all aspects of the federal exchange. **Co-chair Collins** asked about renting an exchange and if these would be national companies or could they be local. **Senator Goedde** said they did not get into details, but he guessed that when renting an exchange, an exchange would be fairly generic and carriers would probably be national.

The task force agreed to meet again on Friday, January 6, 2012, at 1:30 p.m. The meeting adjourned at 2:13 p.m.