MINUTES
(Approved by the Task Force)

Health Care Task Force
July 30, 2012
Capitol Building, Boise Idaho
East Wing, Room 42

In attendance were Co-Chairs Senator Dean Cameron and Representative Gary Collins; Senators John Goedde, Patti Anne Lodge, Joyce Broadsword, Steve Vick and Dan Schmidt; Representatives Sharon Block, Carlos Bilbao, John Rusche and Elaine Smith. Absent and excused were Senator Tim Corder and Representatives Fred Wood and Janice McGeachin. Legislative Services Office (LSO) staff members present were Ryan Bush and Matt Ellsworth.

Others present at the meeting included Toni Lawson, Idaho Hospital Association (IHA); Kathie Garrett, National Alliance on Mental Illness (NAMI); Tim S. Olson, Idaho Academy of Nutrition and Diabetes, Nez Perce Tribe; Bruce Krosch, Public Health District 3; Ray Amaya, KBOI Radio; Joie McGarvin, America's Health Insurance Plans; Karianne Fallow and Jenn Connor, St. Luke's, PacificSource; Sarah Woodley, Business Psychology Associates; Richard Roberge, Board of Health and Welfare; Brent Olmstead, Magellan Health Services; Penny Schwiebert and Rick Moran, Idaho Health Insurance Exchange Project; Drew Hall, Lori Wolff, Greg Kunz, Russ Barron, Leslie Clement, Richard Armstrong, Dave Taylor and Cynthia York, Department of Health and Welfare; Benjamin Davenport, Risch Pisca; Skip Smyser; Dennis Chuckovich, Idaho Primary Care Association (IPCA); Julie Taylor, Blue Cross of Idaho; Ken McClure, Idaho Medical Association (IMA); Daniel Chadwick, Idaho Association of Counties; Cindy Trail, Central District Health; Sara Stover, Division of Financial Management; Betsy Russell, The Spokesman-Review; Bill Deal and Tom Donovan, Department of Insurance; Lyn Darrington, Regence Blue Shield of Idaho and Business Psychology Associates; James Baugh, Disability Rights Idaho; Norm Varin, High Risk Reinsurance Board; Corey Surber and Sally Jeffcoat, St. Alphonsus Health System; Robin Nettinger, Idaho Education Association (IEA); Roger Christensen, CAT Fund Board; Tony Smith, Benton, Ellis & Associates; Bill Roden, Delta Dental of Idaho; Marnie Packard, PacificSource; Woody Richards, Blue Cross of Idaho; Elizabeth Criner and John Watts, Veritas Advisors LLP; Heidi Low, Ritter Public Relations; Jonathan Parker, Holland & Hart; Jason Kreizenbeck, Lobby Idaho; Colby Cameron, Sullivan Reberger Eiguren; Randy Andregg, OD, Idaho Optometric Physicians; Roger Sherman, Idaho Children's Trust Fund; Darryl Ford; Dennis Tanikuni, Idaho Farm Bureau; Lauren Willis, National Association of Social Workers; Linda Hatzenbuehler and Martha Ekhoff, State Planning Council on Mental Health; Mike Skelton, All Seasons Mental Health; and Lee Flinn, American Association of Retired Persons (AARP).

The meeting was called to order at 9 a.m. by **Co-chair Representative Collins.** He welcomed everyone and called for a motion on the January 6, 2011 and January 6, 2012 minutes. **Co-chair Senator Cameron moved that the January 6, 2011 and January 6, 2012 minutes be approved, seconded by Senator Schmidt, and the motion passed unanimously by voice vote.**

Senator Cameron welcomed everyone and thanked everyone for addressing an important issue facing the nation and the state. **Senator Cameron** stated that the meeting was to gather information and was not meant to get ahead of the other committees appointed by Governor Otter.

Joy Wilson of the National Conference of State Legislatures (NCSL) was the first presenter and provided her analysis of the Supreme Court's recent decision on the Patient Protection and Affordable Care Act (PPACA). Her PowerPoint presentation is available on LSO's website at: http://www.Legislature.idaho.gov/sessioninfo/2012/interim/healthcare0730_wilson.pdf

Ms. Wilson gave a recap of the Supreme Court decision, discussed Medicaid expansion issues and gave an update on insurance exchanges and the various choices for the states. **Ms. Wilson** stated that states must declare what kind of exchange they are choosing by 11/16/12 and discussed whether subsidies are available in a federal exchange. She also discussed essential health benefit packages, deficit reduction plans and the next steps going forward.

Representative Rusche asked if a federal exchange would have different minimum essential benefits packages for each state in a federal exchange. **Ms. Wilson** answered that it was a state-determined essential benefits package unless a state elects not to select one. Then it would go to a default which is a small group plan with the largest enrollment in the state.

Senator Goedde requested that copies of Ms. Wilson's slides be shared with the Task Force and that LSO staff distribute those to the Task Force.

Representative Rusche asked about the ability of national carriers in a federal exchange to match a state's essential benefit package. **Ms. Wilson** answered that national carriers would match benefit packages to each state. **Representative Rusche** commented that the timeline on matching these packages to states was tight, and **Ms. Wilson** stated that national carriers were concerned about this timeline.

Senator Cameron asked how the Medicaid expansion penalty was found unconstitutionally coercive while other mandates were not. **Ms. Wilson** answered that the Supreme Court emphasized how large the Medicaid program is and that the penalty was all Medicaid money. This distinguished it from other programs. **Ms. Wilson** stated that the federal government likely will not tie penalties to all money in a program going forward. **Senator Cameron** then asked if the wording around the Court's decision on Medicaid expansion could be applied to other programs. **Ms. Wilson** stated that she heard of one professor who believed that it could, but others think that the door is open but the hurdle is high since other programs don't affect state budgets like Medicaid. She expects additional challenges on the provision in the Court's decision regarding coercion as applied to other programs. **Senator Cameron** then asked about further litigation and issues that may arise. **Ms. Wilson** answered that litigation could potentially arise on whether or not subsidies extend to federal exchanges and on the contraception mandate in the PPACA. **Ms. Wilson** further stated that litigation on subsidies would be solely on whether subsidies exist or not, not about constitutionality.

Senator Cameron then asked Ms. Wilson to outline what's at risk to Idaho or any state should it choose to do nothing in regards to an insurance exchange or Medicaid expansion. **Ms. Wilson** answered that

particular issues to a state such as geography or population will likely not be addressed in a federal exchange because there will be no customization. However the Department of Health and Human Services (HHS) may welcome participation by states in some ways to ease their burden. It depends on what role the state wants HHS to play in its insurance market. The risk is in the state not liking how its exchange is run and not being able to do anything about it, but the possibility exists to switch from a federal to a state exchange. As for Medicaid expansion, **Ms. Wilson** answered that because Medicaid is tied to a state's economy, it depends on jobs and a state's infrastructure and the ability to absorb growth in Medicaid participants. Providers are concerned about states not participating in expansion because of uncompensated care. Each state has to take a hard look at its numbers.

Senator Schmidt asked if the numbers on Medicaid expansion are readily available and agreed upon and if the states that have already declined to expand Medicaid are basing their decisions upon numbers. **Ms. Wilson** answered that most states are not basing it on numbers in declining to expand. They decided beforehand and did not run a comparison. Also, NCSL has not run numbers. Consultants are running numbers in a range. It's a guess and a range of guesses but you get some notion on what you're looking at, but it is not scientific.

Representative Rusche asked if industry transformational efforts such as insurance regulation, no lifetime limits and no denial for pre-existing conditions were unaffected by the Supreme Court's decision. **Ms. Wilson** answered that this was correct.

Senator Goedde asked how the federal government was going to force states to implement an insurance exchange whether it be state or federal. **Ms. Wilson** answered that if a state does nothing to establish a state exchange, HHS will contract with someone to run a federal exchange in the state and its operations, including Medicaid eligibility if necessary. This is what the law requires, but it will be difficult for HHS. HHS will fund this through fees. **Senator Goedde** asked if an insurance exchange was mandatory in one form or another. **Ms. Wilson** answered that this was correct and that if no subsidies existed for a federal exchange, then the exchange would become non-functional because there would not be enough enrollment in an exchange to make it sustainable.

Senator Vick asked if it was correct that there was no funding in PPACA for state exchanges. **Ms. Wilson** stated that HHS says that there is funding for a state exchange, but she cannot find this wording. HHS says funding will be for the first year, but then state exchanges need to be self-sustaining. **Senator Vick** then asked if funding of a state exchange through fees would be on users of an exchange. **Ms. Wilson** stated that it would likely be fees on carriers which make for higher premiums.

The next presenter was **Director Bill Deal,** Department of Insurance (DOI), who addressed how his department is proceeding following the recent Supreme Court decision on the PPACA. **Director Deal** stated that the Governor or Legislature still has much to determine. Director Deal stated that the Supreme Court decision caught a lot of people by surprise and Chief Justice Roberts took many by surprise by calling the individual mandate a tax. **Director Deal** further stated that the IRS will be dealing with those not participating in the individual mandate and equally surprising was the option on Medicaid expansion for states. Now there are more questions and DOI and the Department of Health of Welfare (DHW) are

dealing with these. He stated that Idaho still has to choose between a state, federal, partnership exchange or decline to act.

Director Deal then discussed what would need to be addressed in the next legislative session such as market reforms implemented by HHS and domestic insurance companies via the PPACA. Many of these took effect in 2010 including the pre-existing condition exclusion for those 19 and under and no limits on lifetime benefits. In 2014, the pre-existing condition exclusion will be for all ages and there can be no underwriting. **Director Deal** also discussed distribution of rates, 3 to 1 community rating, medical loss ratio and rate review. These changes have been implemented under federal law, and Idaho will need to consider whether to put these changes into Idaho law.

Director Deal then discussed the roadmap for DOI as it considers the PPACA. States are all over the map on their approaches to exchanges. Minnesota signed up for a state exchange on July 20 and is spending $41 million. This was done by executive decree. There have been many editorials on what Governor Otter is doing and his organization of working groups on insurance exchanges and Medicaid expansion. **Director Deal** stated that he and Director Richard Armstrong received a letter from the Governor on July 25 that addressed the issues to be considered by the working groups. There are fourteen issues to be considered including costs of choices in exchanges and all available options. **Director Deal** then stated that the first meeting of the health insurance exchange working group would be on August 2 in an open meeting. **Director Deal** then discussed the agenda for this meeting and the outcomes that they are hoping for in all of their meetings. These include answers in full for the Governor; a discussion of the federal mandate for an exchange; an educational process with accurate info for citizens of Idaho including who gets a subsidy for an exchange; comparison of costs for different exchanges; and timelines left for exchanges. DOI has a deadline of August 15 to submit an application for another federal grant for an exchange. DOI will not submit a grant application at that time, but the next opportunity to apply for a grant is in November. **Director Deal** stated that Idaho will need some money from the federal government and that there is a November 16 deadline for the Governor to declare what type of exchange Idaho will have.

Representative Rusche asked about the September 30 deadline for designation of minimum essential benefit package and if Idaho would default to a federal package or make a decision. **Director Deal** answered that they have been working on this for some time. DOI has gathered stats and will be able to comply with the September 30 date.

Senator Goedde asked if essential benefits were determined by the state regardless of a federal or state exchange. **Director Deal** stated that this was correct. **Senator Goedde** also asked if DOI has looked into a rental agreement for an exchange with a private company and that Oklahoma was renting an exchange for around $20,000 per month. **Director Deal** stated that he was not familiar with Oklahoma's exchange or the rental option.

Senator Vick asked if the Governor needs legislative authority to declare an exchange by the November 16 deadline. **Director Deal** answered that Minnesota is proceeding with a state-based exchange via executive order with a $41 million federal grant. He also stated that Governor Otter does not want a special session as he understands it and that declaring on an exchange is a non-binding declaration.

Senator Cameron stated that most Idahoans probably do not want the federal government involved in their health insurance decisions and if there is a state exchange, Idaho can keep the federal government out of these decisions. **Senator Cameron** asked how a partnership exchange would keep the federal government out of Idaho and why this might be a viable option. **Director Deal** stated that since March 2010 Idaho has been working towards a state-based exchange. DOI has not been given direction to move forward though. Now DOI is wondering if it is realistic given the time constraints to establish a state-based exchange. **Director Deal** stated that DOI needs grant money for a state exchange and the earliest they could get implementation legislation would be in the next legislative session in January 2013 which would be past the date when states must be certified for their preparedness. In a partnership exchange, the federal government would handle the web portal and would set up the consumer answering service center. The state would have control of plan management, regulation of insurance companies and other consumer issues including navigator/producer responsibility. **Director Deal** stated that every November states have an opportunity to declare a change in their plans, so Idaho could change its mind on the type of exchange in November 2013, 2014, etc. Many states look at a partnership exchange as a way to get started with the idea of changing to a new system in a subsequent November.

Senator Cameron stated that a partnership exchange would lead Idaho towards the federal government coming into Idaho's health insurance. **Senator Cameron** asked if Idaho can partner with other states in running a state exchange that would allow it to maintain state control rather than HHS running Idaho's insurance industry and if Idaho can do a one-year partnership with other states or private entities doing state-based exchanges. **Director Deal** responded that Governor Otter has asked DOI to look into that. They have talked with Wyoming, Montana and Utah regarding a partnership. It didn't work out because the decision was not made to move forward with a state exchange in Idaho, and Utah is slow to move forward. On the private side, he is not familiar with a private company that could contract with Idaho for an exchange. **Senator Cameron** responded that Idaho should not discount Utah because they are slow. Idaho may want to go slowly. The White House has certified the Utah exchange as a valid state exchange. Maryland purchased a private exchange. It would cost Idaho around $6 million to run an exchange through this company, and this company could get Idaho's exchange up and running by the 2013 deadline. **Director Deal** responded that the state would lose its regulatory authority over the health insurance industry in a federal exchange, and DOI would like to stay away from this.

Senator Goedde asked if Idaho defaults to a federal exchange or elects to enter into a federal partnership exchange, if the option of not expanding Medicaid is still available. **Director Deal** believes that the exchange and Medicaid are two distinct issues.

Representative Bilbao asked about the estimates of money needed to move forward for a state-based exchange and how much to maintain a state exchange past 2014. **Director Deal** answered that DOI needs money to implement an exchange. The federal government has extended the time frame for states to apply for grants, and grants are available. DOI has ballpark figures that need to be refined. He could not estimate the cost after implementation right now. He hopes that the Governor's task force can nail down these costs.

Senator Schmidt asked what makes Idaho unique and what could not be served by a federal exchange. **Director Deal** responded that they are looking into that and he hopes to have more answers after the exchange working group meets.

The next presenter was **Director Richard Armstrong,** Department of Health and Welfare (DHW), who addressed how his department is proceeding following the recent Supreme Court decision on the PPACA. **Director Armstrong** discussed the working group on Medicaid expansion, the questions that the working group hopes to answer and his department's approach to the Medicaid readiness side of eligibility. He then discussed the data being compiled by Leavitt Partners and Milliman on the Medicaid expansion population. This data is to be specific to Idaho and to include data on indigency and the CAT fund. The Department is trying to understand where people in expansion population are receiving services. This report is scheduled to be ready in September. The eligibility requirements for Medicaid remain intact following the Supreme Court's ruling. DHW will be applying for grant dollars from the federal government for system changes caused by an exchange.

Director Armstrong then handed his presentation over to **Russ Barron,** Welfare Administrator, DHW. **Mr. Barron's** PowerPoint presentation and Director Armstrong's handout on the working group on Medicaid expansion are available on LSO's website at:
http://www.Legislature.idaho.gov/sessioninfo/2012/interim/healthcare0730_barron.pdf
http://www.Legislature.idaho.gov/sessioninfo/2012/interim/healthcare0730_armstrong.pdf

Mr. Barron's presentation focused on the three phases of DHW's Medicaid Readiness Initiative, their time frames and their costs. The three phases of the Medicaid Readiness Initiative are: 1) Modernization that improves eligibility and MMIS systems; 2) Expansion and changes to eligibility rules; and 3) Connection to an exchange. For modernization, **Mr. Barron** discussed DHW's current priorities and the expected results. **Mr. Barron** then discussed the impacts of the Supreme Court's decision on Medicaid expansion. He stated that new methods of eligibility are mandatory but expansion of Medicaid is optional. Automated systems must be updated, but Idaho can decide who will be covered by Medicaid for certain groups. **Mr. Barron** then discussed the one-time and ongoing costs for Medicaid expansion. **Mr. Barron** stated that DHW will have to connect to an exchange in some form, but they are waiting on a decision of whether it will be a state or federal exchange.

Senator Lodge asked what income that people receive might not be calculated in Medicaid eligibility and if this includes entitlement programs (slide 10 of the presentation). **Mr. Barron** answered that child support income is now included in determining eligibility but will not be going forward.

Senator Broadsword asked, in regards to grants for connecting to an exchange, if grants will be needed for either state or federal. **Director Armstrong** answered that grants will be needed for either type of exchange and that grants are available. **Senator Broadsword** then asked about Question 9 on Director Armstrong's handout and why the poverty level for determining eligibility was listed as 138 percent when Mr. Barron mentioned 133 percent. **Director Armstrong** answered 133 percent has been followed historically, but the figure of 138 percent comes with PPACA. The working group is looking at a percentage lower than 133 or 138 percent. DHW is waiting on guidance from federal government regarding anything less than 138 percent.

Representative Rusche stated that in his experience people come on and off Medicaid and asked how this will change with different eligibility levels and system changes. **Mr. Barron** answered that he anticipated that this would continue because it was mandatory to have this type of coverage. Also much will depend on MAGI (modified adjusted gross income) and changes to it. But there will likely continue to be issues as this is a very complex question. **Representative Rusche** then asked if providers will have the ability to know of the differences in the rules for commercial carriers in an exchange and Medicaid and the different payment rates. **Mr. Barron** stated that this was correct and why the connection with an exchange was so important because information needs to be shared. **Representative Rusche** then asked what the Supreme Court decision does to the managed care effort and how it affects the timeline and contract supervision. **Director Armstrong** stated that the ruling does not change DHW's desire and enthusiasm to move to managed care. The delivery system still needs to be revised regardless of the Medicaid expansion population. There are a high number of people in expansion population that make up client base for behavioral health. This load could move potentially depending on the decision on expansion. If there is no Medicaid expansion, it will impact direct services on adult mental health and in-state hospitals.

Senator Schmidt referenced slide 10 in Mr. Barron's presentation and asked for an approximation on total budget impact for Medicaid expansion. **Director Armstrong** stated that Milliman and Leavitt Partners are looking at these numbers and the expenses already included. Much will depend on federal funding and the levels of funding as time goes by.

Senator Cameron asked about "woodworking" (those who have been eligible for Medicaid but have previously not participated but are now coming forward following the PPACA) and what level of woodworking they anticipate. **Mr. Barron** replied that they are still working on their estimates and looking for more exact numbers. He believes that it will be between 100,000 and 150,000 people, and whatever number it is, DHW will account for this. **Senator Cameron** then asked what costs other than costs from the counties, the indigency fund and adult mental health that DHW is looking at and if it includes populations such as the corrections population who were not previously qualified for Medicaid. **Director Armstrong** answered that incarcerated people will not be part of Medicaid expansion while incarcerated. They would be immediately eligible when they are released. Others include those in federally qualified health plans.

Senator Broadsword asked if there was direction in the PPACA as to the level of benefit for adults with no children. **Director Armstrong** replied that DHW intends to define this as a unique population along the lines of basic coverage since these are not people with a specific disability.

The next presenter was **Brian Kane,** Assistant Chief Deputy, Office of the Attorney General, who answered any legal questions that might follow from the previous presentations.

Senator Goedde asked about the authority of the Governor to issue an executive order on an insurance exchange. **Mr. Kane** stated that both the Governor and Legislature have authority subject to checks by the other body. If the Governor declares the direction of the state in regards to an exchange by November 16, it will require legislative action, appropriation or authorization for entities involved. If the Governor

declares and the Legislature does not act, the declaration would not be the direction that the state goes. Whatever the Legislature does is subject to a veto. If a veto occurs, then a default would have to be a federal exchange.

Senator Cameron asked about Attorney General Wasden's reaction to the Supreme Court's decision and whether the Attorney General's Office will pursue further legal challenges. **Mr. Kane** stated that Mr. Wasden was surprised much like everyone, but the court has spoken as to what the law now is. He does not believe that further litigation will happen. As to whether there will be a challenge on the issue of silence on subsidies in an exchange, a state would have to have standing. Employers who do not offer qualified plans and then has an employee who purchases coverage and is then subsidized which triggers a federal penalty would most likely be the ones with standing. Right now it is too fresh to appreciate what the next legal steps are.

Senator Schmidt discussed the scenario of there being no agreement between the Governor and Legislature and defaulting to a federal exchange and asked about a potential default for Medicaid expansion if no there is no agreement between the Governor and the Legislature. **Mr. Kane** answered that if there is no agreement on Medicaid expansion, it would be an interesting legal question. There may not be an answer for that scenario at this point. There would be a political vacuum if the branches do not agree on a direction. This is a very involved question on the powers of the government branches.

Senator Vick asked if a tax levied under the PPACA violated Article 1, Section 9, Clause 4 of the U.S. Constitution. **Mr. Kane** replied that the Chief Justice stated in his opinion that the PPACA tax does not violate this provision, and the Supreme Court unanimously said this is not a tax under the tax Anti-Injunction Act. If not a tax here, then how is it a tax under the Constitution? The good news for Legislatures is that they can say that certain statutes can apply differently for different taxes. Chief Justice Roberts also wrote that Congress could not levy this tax under the commerce power but did have the power to do this under the taxing power. The Court looked at the features of a tax and the factors that make it a tax. Congress can now say that the tax Anti-Injunction Act does not apply for a certain tax because they are not calling it a tax. This expands authority for Legislatures.

The next presenter was **Norm Varin,** Vice-chair of the High Risk Board, who gave an update on the High Risk Pool. **Mr. Varin** stated that boards meets monthly and updates the financial status of the program. Current financials are through March 2012. **Mr. Varin** began discussing the Small Employer Program and stated that this program was on a closed loop basis. Members have no idea that they are in the pool. Carriers pay a reinsurance premium for those members and submit claims subject to a reinsurance deductible. Currently there are 82 members in this pool. The pool currently is around $42,000 in the positive. The pool is funded through assessments through the carriers. If there is a deficit there is a reinsurance assessment made to the carriers. The pool functions well. The board tries to keep the loss ratio around 200 to 250 percent, and currently it is below this and better than expected.

Mr. Varin then discussed the Individual High Risk Pool. Members in this pool know they are in the pool and purchase an HRP or high risk pool. Members are eligible in two ways, applying for coverage by an insurance carrier and being rejected or the product and rates received from a carrier exceed products

available in the HRP. Products are decided by statute and premiums by the Board. There are just under 1,800 members currently. Currently the pool is down approximately $547,000, but this is expected. Funding comes from reinsurance premiums, and a portion of the Idaho state premium tax is paid into the pool. The pool has also been building up a reserve via the premium tax, and this reserve should be adequate for the current and following year.

Mr. Varin next discussed the PCIP or pre-existing condition insurance program. This is the federal high risk pool created in 2010 when the PPACA was passed. Idaho chose to let the federal government run this pool. Just over 660 Idahoans are currently in this pool. Someone is eligible for this pool if they do not have insurance coverage for 6 months and are denied coverage by a carrier and if they have a pre-existing condition. Around $24 million was allocated to Idaho for this pool, but **Mr. Varin** is unaware of how much has been spent. Idaho enrollment in this program is under 1 percent of national enrollment.

Mr. Varin addressed the future of the high risk pools as they relate to federal reforms. Idaho statutes would continue until changed. In 2014, assuming no change, people could purchase insurance regardless of risk and pre-existing conditions. PCIP will no longer be enrolling new members in January 2014, and this will likely be the case for the state pool. Transition rules would need to be produced for those already in these pools, but the funds are likely there. In January 2014 there will be transition financial mechanisms similar to the reinsurance mechanism called the 3 Rs: 1) Reinsurance - funding from carrier premiums assessed by the federal government but that can be administered by the state; 2) Risk corridors - if target loss ratio missed by a certain percent, the federal government will help; and 3) Risk adjustment - sharing premiums amongst carriers based on risks received when they take on coverage. Reinsurance and risk corridors are temporary, but risk adjustment is permanent.

Representative Rusche asked about the 3 Rs, who manages them and if they are turned over to the federal government. **Mr. Varin** stated that it depends on the direction the state moves. If Idaho chooses a state exchange, some functions will be managed by the state. If there is a federal exchange, the federal government will run that. Risk corridor is entirely federal though.

Senator Vick asked if it was correct that not all pre-existing conditions are covered under the PCIP. **Mr. Varin** answered that the federal program, PCIP, has been relaxed to allow more people in, but he is unaware of all conditions. **Senator Vick** then asked if there is a new requirement that insurance companies will not have to cover some pre-existing conditions once PPACA is implemented. **Mr. Varin** replied that all conditions must be currently accepted for those 19 years and younger. There may be some limited coverage in essential benefits, but he does not believe that there are any specific conditions that are excluded from coverage.

Senator Schmidt commented on the 3 R of risk adjustment and asked whether insurance companies are evaluating the cost or the risk before cost occurs. **Mr. Varin** responded that the risk adjustment mechanism is a sharing amongst the carriers of the premium and not actual expenses. **Mr. Varin** stated that he hopes they do a good job of knowing what the risk is because carriers still have to recognize their financials.

The task force recessed for lunch at 11:40 a.m. and reconvened at 1:15 p.m.

The next presenter was **Roger Christensen,** Chairman of the Catastrophic Health Care Cost Program (CAT Fund). Mr. Christensen gave the task force an update on the CAT Fund. His PowerPoint presentation can be on LSO's website at:
http://www.Legislature.idaho.gov/sessioninfo/2012/interim/healthcare0730_christensen.pdf

Mr. Christensen, stated that the CAT Fund would affect the decision on Medicaid expansion. In his PowerPoint presentation, Mr. Christensen discussed the average claims paid. He mentioned that in 2010 the CAT Board began working with counties on medical reviews, alternative coverages and applicants going through Medicaid processing first. **Mr. Christensen** stated that the fund's 95 percent reimbursement rate discount will sunset in 2013, and these costs will be factored back in. Costs per case have gone up despite some patients being placed in the PCIP program. **Mr. Christensen** does not anticipate coming to the Legislature with a supplemental funding request.

Mr. Christensen then summarized savings from the CAT program and cost diversions from medical reviews, alternative coverage, DHW's combined application unit and the reimbursement rate discount. **Mr. Christensen** discussed the savings incurred from alternative coverage and the PCIP program. **Mr. Christensen** discussed issues affecting the CAT Fund going forward such as the future sunset of PCIP, the sunsetting of the 5% reimbursement adjustment. Medical inflation has also not been included in estimates. Those not eligible for the exchange will also affect expenditures from the CAT's general fund expenditures and at the county level. Much of the impact on counties will depend on what happens with the Legislature's decisions on health care reform. Will the indigent program continue or will those dollars be used to match on the Medicaid level? DHW is working on these numbers. Another option is to restructure the indigent program.

Representative Rusche asked about alternative coverage and screening out Medicaid eligibles and whether Idaho can expect a 7 to 8 increase in the total amount of CAT fund expenditures. **Mr. Christensen** responded that he expects an increase. Some cost-saving measures such as PCIP will be going away and even with the 5 percent discount, they could be looking at a request next year of $41-42 million.

Senator Cameron asked if there was a $41-42 million request on the state side how much would come from the county side. **Mr. Christensen** answered that the $41-42 million figure was on the CAT side. This $42 million would also include around $3 million in reimbursements. The last report estimated around $60 million total with around $37 million from the general fund. The rest came from the counties.

The next presenters were **Martha Ekhoff and Linda Hatzenbuehler** of the State Planning Council on Mental Health who gave a summary of the Council's 2012 report on mental health. Their PowerPoint presentation and the Council's report are available on LSO's website at:
http://www.Legislature.idaho.gov/sessioninfo/2012/interim/healthcare0730_ekhoff_hatzenbuehler2.pdf
http://www.Legislature.idaho.gov/sessioninfo/2012/interim/healthcare0730_ekhoff_hatzenbuehler.pdf

Ms. Ekhoff discussed the role and vision of the Planning Council and the message that mental health is essential to overall health. **Ms. Ekhoff** then shared a story of a person who sought treatment and was able to recover from his mental illness to lead a productive life. **Ms. Ekhoff** listed the factors necessary for those with mental illness to recover. These include housing, early intervention and access to services in rural areas. The alternatives for those who do not recover are more suicides and more costly hospitalizations. **Ms. Ekhoff** then discussed the trends and numbers of those with mental illness in Idaho across different priority levels and stated the concerns and areas that they will monitor as the state moves towards mental health managed care.

Representative Block asked at what age can we begin to do more early intervention on mental illness and how better can we do this. **Ms. Hatzenbuehler** answered that mental illness is happening earlier and earlier. The system is not seamless right now, and school systems need to coordinate with the mental health system but this is a challenge. If a child is developmentally delayed, there are systems in place. However, behavior problems are often not identified early and these children can end up in juvenile and then adult detention system.

Representative Rusche commented on a report from Region 2 appended to the Council's report that shows increased costs and responsibilities to the corrections system and the judiciary because mental illness was not being treated appropriately and the likelihood that this was consistent across the state. **Representative Rusche** then asked about the status of the mental health transformation project. **Ms. Hatzenbuehler** stated that this was not her area of expertise but she believes that they are moving towards integration at a regional level while moving forward with managed care and addressing new federal legislation. Region 6 is moving forward with integration of the mental health and substance abuse system. This will be a grass roots movement until official rules and regulations fall into place. **Representative Rusche** commented that at a subsequent meeting he would like to hear from the Council, the department that manages the public mental health system and the Governor's office to report on their progress.

The next presenter was **Paul Leary,** Medicaid Plan Administrator for the Department of Health and Welfare, who discussed Medicaid managed care. Mr. Leary's PowerPoint presentation is available on LSO's website at:
http://www.Legislature.idaho.gov/sessioninfo/2012/interim/healthcare0730_leary2.pdf

Mr. Leary began by discussing the Medicaid mental health managed care request for proposal (RFP). The RFP and the contract unit and legal review were recently completed. The award date is targeted for November 2012. **Mr. Leary** then discussed integrated care for dual eligibles or those eligible for both Medicare and Medicaid. They are developing a managed care plan for dual eligibles that will result in an accountable care system and have met with stakeholders and several health plans. This has been an ongoing communication for developing an RFP for a dual eligible plan. Implementation is scheduled for January 2014.

Mr. Leary then addressed the issue of patient-centered medical homes (PCMH). This would be a multi-payer collaborative, and a pilot has been developed. Another pilot called a health home has also been developed that is a medical home model that builds on the health connections program designed for

individuals with chronic disease conditions plus one or more comorbidities or serious mental illness. The Children's Health Improvement Collaborative has been developed via a joint grant shared with Utah which looks at the medical home model for children. For medical health homes, January 2013 is the targeted starting date, and the state plan amendment is in process.

Mr. Leary discussed how DHW is looking at the North Carolina network model for Medicaid managed care. The team looking at the North Carolina model identified four areas to improve patient outcomes which are available in Mr. Leary's PowerPoint presentation. **Mr. Leary** then described how the North Carolina model works, including the use of non-profit community networks, how enrollees are linked to a primary care provider and the use of case managers. The network in the North Carolina model works with primary care providers and case managers and uses peer-to-peer education. The model also has built-in data monitoring. **Mr. Leary** then discussed how this model might be adapted to Idaho and how the Idaho version would include a central office, an advisory board, the networks themselves and measurement and reporting for quality improvement. DHW is sharing this conceptual framework with provider organizations, analyzing the current system, and is looking to gain support of key health leaders in Idaho.

Mr. Leary then discussed the managed care plan development due in a report to the Legislature in June 2013. Actuarial analysis is complete, and the final report is due in September 2012. DHW is currently initiating an RFP for a managed care consultant, and the plan development is ongoing. They have two analysts dedicated to managed care and are recruiting for a deputy administrator for managed care.

Senator Broadsword asked about the North Carolina model and if it has a base amount per-member, per-month fee and if it can equate to something similar in Idaho. **Mr. Leary** answered that for a person with chronic disease, a per-member, per-month fee runs about $15. The primary care physician gets $3, and the network gets $12. Idaho is looking at similar numbers for a health home model.

Representative Rusche commented on the few responses to the recruitment for the deputy administrator position and discussed the need for managed care clinicians and asked if DHW can respond to the market considering the Medicaid plan is a $1.6 billion project. **Mr. Leary** stated that he did not have a definite answer to that but that salary plays a role, especially for a physician. **Representative Rusche** then discussed the need for medical directors for each network and how DHW is trying to meet the demand side while trying to feed the supply side. **Mr. Leary** responded that on the network side, there are people out there with the skills needed. This is a network responsibility to provide a medical director, but he agrees that it will be around 6 or 8 people with these skill sets.

Senator Cameron asked how DHW chose the North Carolina model and if they are looking at any other states. **Mr. Leary** answered that in a forum in December 2011 co-hosted by DHW, the Idaho Hospital Association, the Idaho Medical Association and the Idaho Primary Care Association, the idea was generated by the IHA and/or the IMA because of their success with this model. DHW also had the opportunity to examine the North Carolina model. What they need are primary care champions, or they are looking at other managed care programs. **Senator Cameron** mentioned the Arizona model and asked if DHW is looking at this and other states' models or if they are waiting for a primary care provider to champion the North Carolina model. **Mr. Leary** responded that they are looking at other states. Arizona is a heavily Medicaid managed care state. Alabama, Colorado and Montana use the North Carolina model

as well. They are looking at many models, but if they don't get the right drivers, the North Carolina model will not succeed.

Senator Cameron then asked about DHW's time frame for an RFP and potential barriers other than the need for a champion. **Mr. Leary** stated that the state's decision on Medicaid expansion is a big factor on the benefit side. January 2014 is their target for a decision on whether to expand or not expand. They will have the plan ready for the Legislature in June, and this will give a clear direction on where they're going. With managed care plans, they will need 2 plans to respond to the RFP to move forward.

Senator Cameron asked if the plan is to move forward with segregated populations for managed care or to move forward with all populations and how this will affect how many participate in the RFP. **Mr. Leary** answered that the overall plan is to manage the Medicaid population in total. Dual eligibles, where Medicare is primary, may be managed differently, but ultimately they hope to manage through managed care the whole Medicaid population. **Senator Cameron** then asked about the requirement of an actuarial analysis and when that will be available and also if there are other measures for success. **Mr. Leary** stated that the actuarial analysis was completed last week and that he and Leslie Clement will be in contact with Matt Ellsworth and **Senator Cameron** regarding this analysis. **Mr. Leary** stated that measures for success are critical. Initiatives like health homes and Medicaid quality initiatives give clinical outcomes for measurement. There are quality indicators to see if they are improving quality of health care. On the actuarial side, they will slice and dice by population. They will look at baseline costs for inpatient hospitalization, outpatient services and pharmaceuticals.

The Task Force then took public comment on Medicaid managed care and heard from **Kathie Garrett** of the National Alliance on Mental Illness (NAMI) and **James R. Baugh** of Disability Rights Idaho. **Ms. Garrett** stated that she appreciated the attention that this issue was receiving and that she anticipated cost savings may not be seen immediately. Transition is key for those with mental illness, and implementation must be carried out with a well defined transition plan. NAMI believes that Medicaid managed care must be recovery oriented and community based. **Mr. Baugh** stated his concerns that managed care organizations (MCOs) do not have experience with developmental disability services and how MCOs are going to measure success with what have been traditionally non-medical services.

Senator Broadsword concluded the meeting by commending Leslie Clement, Deputy Director of Medicaid, Behavioral Health and Managed Care Services for DHW on her fine work for the state of Idaho and wished her well as she moves on to other endeavors.

Co-chair Representative Collins adjourned the meeting at 2:45 p.m.