MINUTES
(Approved by the Task Force)

Health Care Task Force
October 7, 2013
Capitol Building, Boise Idaho
East Wing, Room 42

Co-chair Cameron called the meeting to order at 9:00 a.m., and he asked for a voice roll call, pointing out that there were new members on the task force this year. In attendance were Co-chairs Senator Dean Cameron and Representative Gary Collins; Senators John Goedde, Patti Anne Lodge, Steve Vick, Marv Hagedorn, and Dan Schmidt; Representatives Fred Wood, Lynn Luker, Brandon Hixon, Luke Malek, John Rusche and Elaine Smith. Senator John Tippets was absent and excused. Legislative Services Office (LSO) staff members present were Ryan Bush and Charmi Arregui.

Others present at the meeting included Kurt Stembridge, GlaxoSmithKline; Tim S. Olson, Steve Rector, SeAnne Safaii and Sue Linja, Idaho Academy of Nutrition and Dietetics; Paul Leary, Russ Barron, Steve Bellomy, Dave Taylor, Benjamin Johnson, and Lori Stiles, Department of Health & Welfare; Bill Deal, Tom Donovan and Kathy McGill, Department of Insurance (DOI); Molly Steckel, Idaho Medical Association (IMA); Julie Taylor and Jack Myers, Blue Cross of Idaho; Bill Roden, Hopkins Roden/PLLC, Select Health & Delta Dental; Dave Self, PacificSource Health Plans; Kathie Garrett, National Alliance on Mental Illness (NAMI); Shad Priest, Scott Kreiling and Paul Harmon, Regence BlueShield; Stacey Satterlee, American Cancer Society Cancer Action Network; Sara Stover, Division of Financial Management; Jim Baugh, Disability Rights Idaho; Woody Richards, Attorney/Lobbyist; McKinsey Lyon, Gallatin; Tanya McElfred, Nimiipuu Clinic – Nez Perce; Liz Meddaugh, Random Mitchell, Cheyenne Serra, Heather Curry, and Ashley Jensen, BSU Nursing; Kris Ellis, Benton & Ellis; Betsy Russell, Spokesman-Review; Silas Whitman, Nez Perce Tribe; Steve Thomas, Idaho Association of Health Plans (IAHP); Amy Dowd, Your Health Idaho; Jesse Taylor, Gallatin; Christine Pisani, Council on Developmental Disabilities; Mark Donaldson, Saint Alphonsus Health System; Heidi Low, American Cancer Society Cancer Action Network and Idaho Academy of Family Physicians (IAFP); Suzanne Budge, SBS Associates LLC; Laren Walker, High Risk Pool; Elli Brown,Veritas Advisors LLP; Emily McClure, Givens Pursley; Colby Cameron, Sullivan & Rebeger; Brad Hammer & Shawn Hall, NASW; Gary Dickerson, Human Supports of Idaho; and Joy Wilson, NCSL, Washington, D.C., participated via conference telephone call.

Co-chair Cameron called for approval of the September 10, 2012 Minutes and **Senator Schmidt moved that they be approved, seconded by Senator Goedde and the motion carried by a unanimous voice vote. Senator Schmidt also moved that the October 12, 2012 Minutes be approved, seconded by Co-chair Collins and the motion carried by a unanimous voice vote.**

The co-chairs welcomed the new members to the task force and invited all the members to share agenda suggestions for future meetings scheduled on November 4th and December 9th.

Senator Goedde shared with the task force a handout from the Wisconsin State Journal dated October 6, 2013 entitled " Self-insurance for state employees could shake up Wisconsin market," a copy of which is available in LSO.

Joy Wilson, National Conference of State Legislatures (NCSL), addressed the task force via conference telephone call about what other states are doing with regard to the Patient Protection and Affordable Care Act (PPACA). **Ms. Wilson** shared that former "exchanges" are now called "marketplaces." **Ms. Wilson**'s PowerPoint presentation is on LSO's website at: http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1007_wilson.pdf

Ms. Wilson pointed out that many of the partnership states are planning to become state-based in 2015. Idaho and New Mexico are largely state-based, but have some federal functions, at least in the beginning. More recently, the federal government has allowed three states to have a federally-facilitated individual market, but a totally state-run shop, those being Utah, Mississippi and New Mexico. New arrangements are occurring, so she encouraged that if there is a good idea, those ideas should be pursued because she thinks the federal government is open to a wide variety of different approaches. Open enrollment began on October 1, 2013, and runs thru March 31, 2014, but if you want coverage on January 1, 2014, application must be made by December 15, 2013. The good news is that more people tried to get onto various state websites than anyone had anticipated, so there was much more interest than predicted. The bad news, **Ms. Wilson** said, was that October 1st reminded people of "Black Friday" and most people are confused, but kinks are being worked out and there is a big knowledge gap that must be bridged quickly. She believes that when state and local governments get involved in public relations, it makes a huge difference. Advertising efforts to educate everyone are proving effective, but there is much work to be done. **Ms. Wilson** said that the navigators, assisters, agents and brokers are critical to this process since people's knowledge base is very low and help is needed.

Ms. Wilson said that many people believe that once a person goes to the marketplace that the PPACA gives free health care, which is not true; the rates vary tremendously from state to state. At the end of her PowerPoint, she listed resources about premiums. States having the highest rates are Alaska and Wyoming, since they have low populations and less competition. She said that insurers are being cautious since nobody knows how this is going to work. She shared that Idaho's rates come out pretty well, and this is important, particularly to young people.

Insurance market reforms as part of the new PPACA package, coming in 2014, include the following:

- Prohibits preexisting condition exclusion;
- Requires guaranteed issue/guaranteed renewal;
- Premium rating rules;
- Non-discrimination in benefits;
- Mental health and substance abuse services parity (final rule due by the end of the year);
- Prohibits discrimination based on health status;
- Prohibits annual and lifetime caps;
- Treatment of same-sex marriage. (Because of the recent federal decision to treat same sex couples with parity in the federally-facilitated exchanges, they will do that; in the state-based exchanges, the state will decide whether or not they will recognize same-sex marriage.) **Ms.**

Wilson said there is a document that goes through the details, and she offered to get this document to LSO for distribution to the members.

Ms. Wilson shared that there is individual responsibility, reminding that there is a modest penalty in 2014 for non-coverage and how it applies with regard to age and family composition, and after 2016 it will be increased by the cost of living. People are confused about who must get coverage and her slides showed the exceptions and exemptions, noting that HHS has said that in states who choose not to expand Medicaid, individuals who then end up ineligible for Medicaid and also ineligible to participate in the exchange will not be subject to non-coverage, but an individual responsibility penalty. That will be a hardship waiver, she said.

Ms. Wilson cautioned that seniors are being targeted for personal information, under the guise of signing them up for PPACA, so it's very important to warn seniors that they are not giving away personal information to scammers. This also applies to singles and families, but the seniors are more vulnerable. She encouraged legislators and everyone to protect seniors and she said that citizens are going to certified navigators to get assistance as needed. Help to small businesses is also important; even though penalties for small businesses have been delayed, there are reporting requirements for all businesses. Employees must be notified about the availability of coverage under the exchange, or if businesses are providing coverage, they need to notify employees of coverage offered by the business. **Ms. Wilson's** resource list on her PowerPoint link included contacts to the Small Business Administration (SBA) and the U.S. Department of Labor (DOL), and those links included forms to be provided to employees to fill out. She encouraged legislators to educate citizens and be a resource in getting people to understand whether they want coverage and where they should go with questions. If legislators want flexibility on something about the marketplace or Medicaid expansion, now is a good time to start thinking about that, and HHS is open to ideas. She encouraged legislators to be involved in this process to provide significant oversight to make sure that things go well and that awareness might lead to something that needs to be done legislatively. **Ms. Wilson** invited questions.

Co-chair Cameron asked what effect the government shutdown and/or lack of funding may have on the exchanges, if any. **Ms. Wilson** replied that HHS has furloughed a number of employees, but kept essential people working on the exchange, so HHS is not fully manned. With regard to the funding issue, most of the marketplace funding is mandatory, so not subject to appropriation, so it will remain funded, and she hoped the shutdown would be over soon so that employees could work on details. A prolonged furlough could compromise efforts to work out kinks and get final rules done. **Co-chair Cameron** asked if the marketplace isn't subject to appropriation, what parts of PPACA are subject to the appropriation. **Ms. Wilson** said that a broad number of grant programs are funded through PPACA, not having to do with the marketplace or Medicaid expansion. **Co-chair Cameron** requested a copy of that list and she agreed to provide that.

Representative Rusche asked about the national for-profit plans and carriers and if they were playing in the individual marketplaces. **Ms. Wilson** said they are, adding that they are being very selective and tend to play where they are already concentrated. She thinks that all carriers are being strategic in their participation. Other carriers aren't necessarily willing to go into competition, but are waiting to see how things go. However, in some states, there seems to be much competition. **Representative Rusche** asked

if a difference had been noted in the profit versus the not-for-profit carriers and **Ms. Wilson** said she had not looked at it like that, but she agreed to research that question.

Representative Wood commented that broadcasts on cable news create confusion, in his opinion, with few answers, and he asked about people associated with vendors in the past few months. Glitches were anticipated in the rollout, but mostly with respect to capacity and not software programming glitches. **Representative Wood** asked what she was seeing. **Ms. Wilson** responded that on the software side, she had heard that the glitches are in hooking up the state and federal to work together, adding that it's different for each state. She said that some states crashed because of capacity. Clearly, there is work to be done.

Co-chair Cameron asked if all the states are busy trying to adapt to whatever type of exchange they chose, asking if she expects states to change from what they chose initially, or is it too early to tell, especially since 2014 is an election year. **Ms. Wilson** answered that a number of states have said that they want to go from being a partnership to a state-based exchange, and she thinks the next several months will determine whether they do that or not. Some states have federally-facilitated exchanges but are taking on some operations which they may or may not expand. The next few months will determine what states do from here and many states, she thinks, will operate their own small business exchange and she thinks HHS would be happy to let states do that. NCSL has asked for this from the beginning, and were not successful, but now the wisdom of allowing states to do what states have done for so long, work with small businesses, is being recognized. New Mexico, Utah and Mississippi have been given the go-ahead to have their own shop exchange, and she believes that other states will follow. If things start moving smoothly, she believes more states will be interested in the whole branding with the state and having more say on how the exchange is operated.

The next presenter was **Mr. Steve Bellomy**, Bureau Chief, Audits and Investigations, Department of Health and Welfare (DHW), and his PowerPoint presentation entitled "DHW – Medicaid Program Integrity" can be found on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1007_bellomy.pdf

Mr. Bellomy introduced Dave Taylor, Deputy Director; Lori Stiles, Medicaid Program Integrity; and Ben Johnson, Welfare Integrity Unit. He gave an overview of the audit and investigation organization at DHW. **Mr. Bellomy** explained that the criminal history unit provides background checks and fingerprinting to include:

- Checking FBI and Idaho State Police criminal records, child and adult protection registries, Medicaid provider exclusions, nurse's aide registry and drivers' records;
- Required for workers who provide direct care for children, the elderly or people with disabilities, includes child care workers, foster and adoptive parents, and employees in long term care settings;
- 26,000 annual applications and 300 denied.

Internal Audit provides management with independent appraisal and feedback of operations and systems to include: accounting controls; management controls; and identifies performance solutions and opportunities.

Mr. Bellomy then focused on welfare and Medicaid program integrity and he explained that the welfare fraud unit investigates recipients for all programs and non-Medicaid providers for all benefit programs including food stamps, Medicaid, child care, cash assistance, energy assistance, women, infants and children, as well as providers. Complaints from the public and internal referrals from department eligibility workers have been constant. There has been a dramatic increase in the number of cases identified for possible audit or investigation. Data analysis has improved productivity tremendously by focusing on the most likely offenders. The average number of cases an investigator closes with an overpayment, a program sanction or prosecution has increased from 50 annually to 200 at the end of FY 2014. The increased productivity has transformed the cost benefit ratio of welfare fraud for the first time and the unit recovered $10,000 more than total costs for a surplus of $6,000 to the General Fund. This is a significant achievement considering the difficulty to recover benefits from recipients. They are seeking four additional investigators in the next session. In 2011 the legislature authorized eight additional Medicaid analysts which came with one requirement, to track and report the cost benefit of the Medicaid program integrity unit expansion. In FY 2012 they did a little better than break even in the General Fund although they recovered nearly one-half million more in receipts than the total costs that first year. In FY 2013, $1,215,339 was recovered, more than total costs, with $574,810 going to the General Fund.

Mr. Bellomy stated that the Medicaid program integrity has a significant impact on cost avoidance. Although impossible to measure, he gave an example that over the past five years, the results were tracked against the full universe of claims for that study group, encompassing more than 40 audits. Total benefits have steadily declined, with cost savings as much as $34 million. Program integrity does make a difference. The program, he said, has some great opportunities and big challenges. Data analysis has driven dramatic improvements in productivity, seeing significant improvements in the Medicaid program integrity, as seen in welfare fraud. PPACA required them to procure the service of an outside recovery audit contractor which accomplishes basically the same thing as his unit, and the first preliminary finding report was completed recently, providing more technical expertise in some Medicaid areas that are difficult to audit. He said those results of the recovery audit will be shared when available. Finally, one of the biggest challenges is in the area of managed care. **Mr. Bellomy** said they are working with Medicaid to review how Idaho should provide oversight and continue state audits as well. He then provided the task force with information on the legal issue of the "Seasons of Hope" case. The first action occurred in March of 2013 and, after a hearing and appeal, they received notice of a potential tort claim the end of September, and that claim is now with risk management. He could not comment on the tort claim, but he added that the department has refrained from engaging in public debate over this action. He is confident that actions were warranted, justifiable, and that both will be proven at the end of this process.

Co-chair Cameron pointed out that several presentations at this meeting had been required as reporting back to this task force and he expressed his appreciation to the presenters for fulfilling that requirement.

Senator Goedde asked about what the integrity unit is doing, focusing on the IEP and Medicaid reimbursement. As he understood this, Medicaid manages federal funds, in certain instances the services required under individual education plans, asking if his unit had been auditing school districts and what portion of the numbers shown had come from school districts. **Mr. Bellomy** replied that the slide shown was actually on special services covering a wide range of medical services provided in the education

environment. Unfortunately, many services were not being used for medically-necessary services or were improperly billed; they were being used for educational services, and this is not allowed under Medicaid rules. **Senator Goedde** asked how many districts were penalized and the response was that only one school district so far had been penalized for one egregious issue, and the remaining districts were asked to recoup the non-allowable services amount. **Senator Goedde** asked how much the penalty was for that one district and **Mr. Bellomy** agreed to get that information for the task force. **Senator Goedde** expressed concern in assessing penalties from one agency of government against other agencies of government which, ultimately, in the case of school districts could fall on the back of taxpayers.

Representative Rusche asked about the perpetrator of fraud or inappropriate payments under Medicaid, wondering if it was typically the beneficiary or the provider, and **Mr. Bellomy** answered that there is no empirical evidence one way or another. However, there are far fewer providers than there are recipients. The providers have by far the largest dollar losses that they encounter and recipients are sometimes multiple-benefit recipients. They are not getting to the majority of the clients, and they do better on the provider side. With a large population of potential cases, they are hoping that four additional staff can help. **Representative Rusche** clarified that there is more individual opportunity as far as beneficiaries, but much greater dollar recovery from providers, and **Mr. Bellomy** confirmed that to be true. The average claim per client is below $10,000 and the average recovery on a provider is from $10,000 up to $1 million or more.

Representative Hixon asked about methods of recovery for fraudulent recipients and **Mr. Bellomy** replied that they are really talking about waste, fraud and abuse, and they are different. The majority of cases are not fraud related, but are abuse, waste and improper billings. The majority of those are recoverable for recoupment, and there is no intention of terminating a relationship with a provider, unless fraudulent or abusive. Overpayments may become legal debts, government debts, and recovery avenues are pursued.

Senator Vick asked about the significant increase in welfare fraud data leads and how many result in an actual finding. **Mr. Bellomy** answered that it takes one to ten hours to investigate a case and that is lost time if nothing is found. Data analysis has provided them accuracy in the 90% range. Public complaints are the most difficult, and the worst cases are from leads. **Senator Vick** asked for an explanation about investigations being done with no dedicated staff. **Mr. Bellomy** explained that his department was very efficient and lean, adding that they don't use dedicated support staff; they manage and process their work individually.

Representative Luker asked about prevention, obviously being the best route, asking if system changes were being identified to help with prevention. **Mr. Bellomy** stated that they meet quarterly with the program to discuss findings and issues, an example being county jails. Food stamps are not needed when incarcerated, so a method was implemented to catch those cases and to warn people as well. **Representative Luker** asked about not being eligible and what was being done. **Mr. Bellomy** said there are rules about when benefits stop and restart, if incarcerated, so they wait thirty days to take action, not knowing how long someone might be incarcerated. **Representative Luker** then asked if Medicaid fraud prevention or welfare fraud had a 50/50 match in funding. **Mr. Bellomy** said it depended on the program, adding that Medicaid is funded at a much higher rate (70-75%) depending on the rate each year. Food

stamps are 100% federally funded, so every dollar that is recovered is called "retained incentive," so every dollar recovered, they get to keep either 20-35% depending on the violation. Some programs are 100% state, some cash programs, and others are 100% federally funded. **Representative Luker** asked about fraud prevention and does funding come directly out of those programs or is there a separate fund for fraud prevention. **Mr. Bellomy** explained that when he said "dedicated" he meant "assigned" and that previously when he mentioned dedicated support, he was referring to support staff and not funding. Administratively, the cost of staff is funded about 50% in every program.

Senator Hagedorn asked for a "snapshot" of where most investigations and time are spent, looking at future legislation. **Mr. Bellomy** agreed to provide the task force with that information and they can look at this in terms of recoveries and number of cases. On the welfare side, at a minimum, about 75% of cases include food stamps, but all programs are examined, with more than 200,000 recipients. **Co-chair Cameron** agreed that he would like to see some pie charts also.

Co-chair Cameron asked about investigation of school districts for utilizing funds allocated for services other than education and what has to happen to rise to a level of a penalty. **Mr. Bellomy** replied that there was only one case and the issue was that the school district had hired an individual convicted of a felony or Medicaid fraud and those services cannot be paid for; that person is not eligible. Every claim cannot be audited. The only thing that can be collected is what is found, so the penalty does two things in statute: (1) it provides a way to recover the cost of doing the audit, and (2) it provides a deterrent for punitive measure against claims that do not get looked at. **Mr. Bellomy** said that a conscious effort has been made to delay the use of penalties because the school districts are really struggling with this, and it's not entirely their fault. Without a penalty, there would be no impact to waste in any program. **Co-chair Cameron** said in this case, a felon was hired and the school district refused to act, so there was no other choice but a penalty, asking if that was correct. **Mr. Bellomy** explained that it was more a matter of "should have known" and if a background check had been done, that information was accessible. **Co-chair Cameron** thought that a penalty may be valid, but said he was trying to define the line of restraint. He asked for a report of other actions from school districts and how issues had been resolved, in order for the task force to see both sides of this penalty issue. **Senator Goedde** thought that 14 school districts had received civil penalties, adding that this did not quite jive with testimony shared at this meeting, asking also for this report. **Mr. Bellomy** conferred with another person from his department and then replied: "I stand corrected. We did have a few, and I will give you the report on those. I thought it was just one. That is my mistake." **Co-chair Cameron** asked also for an explanation of the circumstances and why it was necessary for a penalty, since things are so tight with school districts.

Senator Schmidt asked about the slide on page 13 of Mr. Bellomy's PowerPoint presentation on Medicaid integrity, trying to understand the scope and the relationship between general and federal funds; his question was the total number of $2.4 million of total receipts in overpayments having been described as mostly waste, overpayments, and recollected funds. The denominator, he assumed, was the total payments out of Medicaid, which is over a billion, leaving a percentage being considered waste. Has his department looked at that rate of considered waste and is the state of Idaho in the ballpark of the right amount we should be recovering, or is there more out there we should look for. **Mr. Bellomy** answered that he didn't know Idaho's ranking and every state measures this differently. Compared to other states, Idaho is nowhere near the top, but in the middle, and there is a lot more to be done. **Senator Schmidt**

asked for clarification: "With more effort, more could be recovered, is that correct?" **Mr. Bellomy** replied "absolutely, we can do better at recovering and identifying, compared to other states."

Representative Rusche said in his past experience as a physician, that the most savings was not from case review or investigation, but rather identification of trends and putting edits and policy changes in place. "Is quality improvement cycle on payment accuracy part of what Mr. Bellomy's division does in conjunction with Molina?" **Mr. Bellomy** answered that is not part of what they do. They participate with that, as they do with welfare and also with Medicaid, once a quarter when cases are reviewed and issues occur, and mostly have to do less with edits than inappropriate behavior outside the realm of an edit. **Mr. Bellomy** said he agrees that the cost of front-end avoidance is far cheaper than at the back end. He clarified that with regard to the school districts, there is a special study and there are other cases they are working on. If a complaint is received about abuse, he said that it needs to be clarified which part of the special study relates to the penalties that members had asked about. **Representative Rusche** asked: "Whom, on the automated claims payments side, the edit side, would I talk to about how you two are interacting." **Mr. Bellomy** said they work directly with the Division of Administration and they meet once per quarter.

Ms. Amy Dowd, Executive Director, Your Health Idaho, the Idaho state-based exchange, was the next presenter and she updated the task force on Idaho's insurance marketplace. Her PowerPoint presentation entitled "Your Health Idaho" is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1007_dowd.pdf

Ms. Dowd shared background information on the exchange and the phases of development. The state-based marketplace was successfully launched in Idaho on October 1, 2013. This includes a full outreach program, a full consumer connector program, and a limited scope consumer resource center. The exchange is expanding access to health coverage by building a competitive marketplace for Idahoans to shop for health insurance, and the core is bringing together buyers and sellers of a product. A business was started, including set-up, insurance, governance, all without funding from any state resources, being fully funded with federal grant money through 2015. Phase 2 includes developing a plan for long-term sustainability and migrating to an Idaho based technology solution and full-scope consumer resource center for Idahoans, creating a self-sustaining marketplace by January 1, 2016.

Ms. Dowd informed the task force about the board and staff, guiding principles, what is a federally facilitated marketplace, advantages of a state-based marketplace, the future of "Your Health Idaho," timelines, outreach and education, media coverage, a website, consumer connector locator, outreach and material development, next steps, goals, solutions, consumer connector program design – 2014 and 2015 open enrollment, and statistics on the information consumer resource center.

Senator Hagedorn asked if the call center employees were state employees and **Ms. Dowd** replied the employees were contracted through Pro-People and Your Health Idaho pays 100% of their cost.

Senator Goedde asked about data being entered online. If a person left the site and returned, would that data be saved or would everything have to be entered again. **Ms. Dowd** answered that it is her understanding that the information is saved. **Senator Goedde** asked about the critical need to educate

seniors and asked if any marketing was being developed to educate seniors. **Ms. Dowd** said that Your Health Idaho does not offer plans for Medicare-eligible individuals, but said that outreach education materials would be enhanced to say who the exchange is for and will indicate that it is **not** for Medicare-eligible individuals.

Senator Vick said that the federal government charges 3.5% to use the federal exchange, asking if Idaho was charged anything for using the federal platform. **Ms. Dowd** replied that Idaho has a state-based exchange and will be charged nothing, so the only fee is the 1.5%, self determined through the board, to build up Idaho's reserves in order to be fully sustainable by 2016. **Senator Vick** asked about referral of a customer to a broker; does the exchange still get the 1.5% fee? **Ms. Down** answered "yes, and the broker fee is already built into the cost of the health plans offered on the marketplace." **Senator Vick** asked if that was only if the broker was part of the exchange, and **Ms. Dowd** clarified that the commercial market remains in place, so if an individual uses a broker, that broker is paid a commission by the carrier, so there is no change to that, with the marketplace in place. On the individual market, the fee to use a broker is built into the rate, so not an additional fee. If a person chooses to use a broker, that person doesn't have to pay anything additional.

Representative Luker asked about data integrity, having seen lots of reports from assurances to concerns, adding that our enabling law requires the board to give the Governor and the Director (DOI) a certification that the data is secure before applications are taken, wondering if that had taken place. **Ms. Dowd** said that a meeting took place on September 30, 2013, where Your Health Idaho had to present a letter of certification from the Board and the exchange that went to the Governor and Director (DOI) stating the steps taken to ensure the privacy of Idahoans' protected health information. The Federal Data Services hub had passed that certification and Your Health Idaho did not have documented verification on the marketplace, so they had a CMS representative join the board to call and verbally testify that security clearance had been approved and that documentation was spoken to, even though not provided. Everyone has been trained and certified to be able to ensure that private health information is held secure. **Representative Luker** asked if a copy of that letter could be made available to the task force members and **Ms. Dowd** agreed to provide that.

Representative Malek asked when revenues would start flowing in from the exchange. Are revenues going through the federal government and are liabilities being incurred now that won't be paid back until revenues flow, or are we still on federal grant dollars. **Ms. Dowd** replied that Idaho is fully funded with federal grant dollars for 2013, 2014 and 2015. Starting January 1, 2016, Idaho must rely on revenues coming in through their assessment.

Co-chair Collins asked about how the navigators work and if they are federal, having established a call center here in Idaho. **Ms. Dowd** answered that in-person assisters can be paid for with grant money to get started in 2013 and trained and certified by Your Health Idaho, to help people with facilitated self enrollment. If there is a question on what plan might be best for a person and their family, that person is immediately routed to an agent or broker. There is a resource available, based on where a person lives, to direct that person to certain agents or brokers. That agent or broker can advise on a plan best for that applicant. Next year Idaho will be required to have a self-sustaining navigator program. **Co-chair Collins** asked if the term "in-person assisters" was a new term for "navigators" and **Ms. Dowd** confirmed

that. **Co-chair Collins** then asked if they will be at different locations (in person) and **Ms. Dowd** said that the Hospital Association, the Primary Care Association and some clinics across the state have trained staff within walk-in facilities ready for patients, possibly after realizing they don't have insurance or can't afford the recommended care. That staff will include a financial counselor and options will be presented to patients. There will be coverage across the state available to ensure that patients, even in remote locations, will be referred to the closest location for in-person assistance, if they so choose. **Co-chair Collins** inquired about when Idaho will pay the navigators through our exchange and who will set the pay for those individuals. **Ms. Dowd** said this will have to go through the board for approval on how that program will work, how much these entities will be paid, and options will be explored.

Senator Lodge commented that she had just gotten onto the Your Health Idaho website and with regard to the consumer resource center, she clicked first on "individuals" and then "agents" and she found one she knew which displayed his information and phone contact. She wondered about taking that contact information and calling that agent, without saying she was going through the exchange, since this agent is also in the telephone book. **Ms. Dowd** said that a person could do exactly that, and that it would be fine to do so. **Senator Lodge** asked if was okay to get information from the website and then go to a broker and bypass the exchange totally, and **Ms. Dowd** said that could be done and that broker or agent could advise the individual on products, both inside the marketplace, as well as products outside the marketplace. **Co-chair Cameron** added that most brokers will still be looking in the exchange because there are other reasons why a person would want to participate in the exchange, so most brokers will be assisting in that arena. **Co-chair Cameron** also clarified about the fee and the fact that we are not paying to use the federal platform this year. He thought it was important for the task force to hear that it was due to the efforts of Governor Otter that we are not paying for the platform, since the Governor had negotiated that arrangement with our federal partners, and **Ms. Dowd** confirmed that to be correct. **Co-chair Cameron** gave thanks to Governor Otter.

Ms. Dowd continued her PowerPoint presentation, addressing financial management, federal grant funding, self-sustainability projections, plan management, Idaho's plan choices versus other states, and what a person needs to enroll.

Co-chair Cameron commented that he had tried to get onto the website without luck, the first week of operation; another employee in his office was successful logging on to the Hispanic website. **Co-chair Cameron** responded to **Representative Luker**'s question and shared that both he and **Co-chair Collins** had gone through the federal training and he looks forward to that being state training in the future. After being licensed for 30 years, he said this online training was supposed to take 3.5 hours, but actually took four times that long.

Senator Hagedorn asked about one slide in **Ms. Dowd**'s presentation on operating expenses and assessment fee revenue or reserve, commenting that it looked like operating expenses from 2014 through roughly 2018 is around $12-13 million annually. Assessment fees and reserve look really good in 2015, at about $10 million, and in 2016 when the state becomes fully self-sustainable, he asked what the need is for an additional $50 million grant from the federal government to put this together. **Ms. Dowd** responded that the amount was to purchase the product, driven by market rate, and assistance with implementation through professional services and system integrators, those resources being very

expensive and requiring a specialized skill set. **Senator Hagedorn** said he assumed then, that the capital investments were not included in the operating expenses, and **Ms. Dowd** said she thought that was correct. **Senator Hagedorn** requested a graph showing both operating and capital expenses projected out to better see how that correlates to revenue, and **Ms. Dowd** agreed to get that information to the task force.

Representative Rusche congratulated the staff of Your Health Idaho on the uphill climb to implement this product online by October 1. If there are any questions, comments or feedback, he announced that he was on the board and he would be happy to receive that input for the board.

Representative Malek inquired about how much money was being projected for reserves from fees and **Ms. Dowd** replied that the assessment fee will be collected in 2016 from the carriers, but enough was needed in reserves to pay bills starting in 2016, when self sustaining. A graph with figures was in her presentation, showing the reserve to be about $4 million in 2016. **Representative Malek** asked about migration of data and would that cost be grant funded, given the timing. **Ms. Dowd** affirmed that was grant funded.

Co-chair Collins commented that it was anticipated that by the end of 2014 that there will be an additional 75,000 uninsured people being insured, asking how many will be subsidized. **Ms. Dowd** did not have an exact figure for that, but she guessed at least 90%, and she agreed to follow up on that with the task force.

Representative Hixon asked about the $50 million for phase 2 and if there would be new programs in the latter years, believing that most of the expense would come up front in forming the exchange. **Ms. Dowd** said looking 2-5 years out, she did not know if there would be additional requirements about Idaho's state exchange or where that money will come from and if there will be additional grants. She did know that Idaho has grant money through 2015, and she assured the members that they will maximize the use of that money up front to build a low operating cost model for Idaho. Compared to other states, if Idaho is able to implement a full state-based marketplace with the money available today, Idaho would be the lowest to be up and running. She doesn't think much additional money will be needed to complete the process, significantly less than $50 million, hoping this amount will suffice through 2014 and cover operating costs for 2015.

Co-chair Cameron asked **Ms. Dowd** to provide the task force with her contact information and others involved in Your Health Idaho as they deal with constituents to work through this process.

The task force recessed for lunch at 11:55a.m. and reconvened at 1:30 p.m.

Mr. Laren Walker, Administrator, Idaho High Risk Reinsurance Pool, presented next and updated the task force by giving background information on this program by stating that the pool covers high risk individuals in Idaho. The pool is funded through premiums from insurance carriers that cede people into this pool, a portion of state tax revenue, and an assessment, and he said the pool has been in existence since 2000. He believes this pool operates very efficiently.

Mr. Walker's PowerPoint presentation entitled "Monthly Operation Report – June 2013" is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1007_walker.pdf

Mr. Walker went over plan types, number of lives, total lives, and total ceded risks numbered 1,890 in early July, 2013. Since inception, the pool has served 10,357 individuals, averaging about 1,800 per month in the program. **Mr. Walker** showed a chart of individual policies broken out by carriers reinsured by this program. Insurance companies underwrite policies and then cede those policies into this reinsurance mechanism to pay premiums to this pool and the pool pays back the claims submitted, based on the plan of operation, having deductibles and co-insurance. Children also benefit from this pool and there are currently123 dependent children, 162 individual children, totaling about 285 monthly. His graphs broke out ceded lives per plan design, monthly reinsured lives, claim history, a list of large claims paid for 2012/2013 including ages, gender and diagnoses.

Co-chair Cameron disclosed that he and **Co-chair Collins** were on the high risk committee, and added that it surprises him about the number of people dropping or terminating coverage, and he wondered about the total amount of claims paid out since inception. **Mr. Walker** responded that he would get that information for the task force, guessing that amount to be $50-70 million.

Representative Luker asked about where the pool was headed with PPACA being implemented. **Mr. Walker** said there was no legislation yet to impact the pool at the state level, but it is obviously anticipated that there will be a significant migration out of the pool and into the exchange effective January 1, 2014. This program will be kept in place to allow that migration to happen, anticipating that benefits will be richer in the federal program and premiums could potentially play a factor, which may cause some people to remain in the pool. This will be monitored, and legislators did not want to repeal a successfully working program before determining the effect of the PPACA transition. **Co-chair Cameron** shared that it was the board's intention to let the pool ride for this year, to be evaluated in 2013. Some states have moved their pool to more of a reinsurance mechanism, so Idaho may want to consider that in the future. **Mr. Walker** said there are about 40 states that have high risk pools and about half terminated them effective January 1, 2014, and the other half are doing as Idaho is doing, leaving the pool in place and allowing attrition to take place. **Mr. Walker** shared that he got his exchange renewal letter and that, for his family coverage, there will be a 147% increase on an individual bronze policy, guessing that some people will opt not to go with that option.

Representative Rusche recalled that the exchange must have risk equalization mechanisms, with federal money available for the first few years, but after that it must be a function of the exchange, and he cautioned that before the "plug is pulled" on the fairly stable pool, he advised "putting it on the shelf in the future, but possibly not throwing it away." **Mr. Walker** replied that was wise counsel, adding that several other states are doing just that. He said there is a three-year federal reinsurance mechanism that begins January 1, 2014, until 2017 at which point it goes away, perhaps shelving Idaho's pool but leaving it in place so that it could be used at that juncture as a potential reinsurance mechanism.

Senator Schmidt asked about what seems to be the popularity of the HSA package offered and the details and why it is so attractive. **Mr. Walker** answered that the carriers see the reasons why, guessing

the answer to be rate-driven, since premiums are much lower. Also, with high-risk individuals who may go into remission with cancer, the idea of saving and then using when necessary is also an attractive feature.

Representative Luker inquired about the changes in the PPACA to HSA limits and high-risk deductibles and if that would affect the pool. **Mr. Walker** didn't think so; if any tend not to migrate out of this program, he would think it would be weighted toward those HSA individuals. **Co-chair Cameron** said that the benefits of the plan itself are exempt from PPACA requirements, so they can retain, but there are some indirect effects. Rates are established by polling like-minded products and voted on, one concern being that if rates are not reflective of the marketplace, or so much lower, people will choose a non-ACA compliant plan just to pay that lower rate. If equivalent, he predicts people moving off the high-risk pool and onto richer benefits, particularly if getting a tax credit. It may be different for various ages and conditions. **Mr. Walker** said that in the first quarter of 2014, if lives migrate over to the exchange, it may be July, 2014, to see the full impact of the PPACA to the high risk pool. **Co-chair Cameron** mentioned that based on a good ruling by DOI, even though a plan might not be compliant, no one must make a decision to move until renewal. It will take time for this transition to occur.

Senator Goedde, while waiting for the next presenter to come to the podium, reported that as of August 13, **Mr. Bellomy** had identified 29 school districts that had been asked to return Medicaid money and 12 of those districts were egregious enough to be penalized.

Co-chair Cameron announced that **Mr. Paul Leary**, Medicaid Plan Administrator, Department of Health and Welfare (DHW), would next address the task force, giving an update on CHIP-B and Access Card programs and addressing DHW's Managed Care Report, as well as updating the members on HB 260 initiatives and Medicaid enrollment in FY2014. **Mr. Leary**'s PowerPoint presentation can be found on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1007_leary.pdf

Mr. Leary updated the task force on the CHIP-B and Access Card programs, saying that the number of individuals has changed minimally and very few children are left on the access card, most having moved to direct benefits. The number of children required to pay a premium as of June, 2013, totaled 13,688, and approximately 70% have earned Preventive Health Assistance (PHA) wellness points. **Mr. Leary** addressed recent outreach activities and premium assistance authority changes.

Senator Hagedorn asked about the 70% earning PHA wellness points, and asked about roadblocks for the other 30%. **Mr. Leary** replied that notifications are sent to families informing them that points are available by keeping a child's wellness immunizations up-to-date; some choose not to respond to that, or they just pay the premium.

Senator Schmidt wondered about how many adults are below 100% of the federal poverty level who currently have premium assistance, and **Mr. Leary** replied there is not a firm number, believing it to be just a handful, adding that DHW wants to get a handle on that.

With regard to Idaho's Managed Care Report, **Mr. Leary** stated he had sent out a report in July, 2013, and he updated only a few sections of that plan including dental services having been outsourced to Blue Cross of Idaho. He also covered behavioral health managed care, and integrated managed care for dual eligible.

Representative Rusche asked about DHW's dental target for access and preventive services for Medicaid children, and **Mr. Leary** responded 100%. **Representative Rusche** said that DHW was reaching 60%; what programs does DHW or a contractor have in place to improve that percentage? **Mr. Leary** answered that the Smiling Stork Program was for pregnant women and the Dental Home Program is for children 0-3 years of age. DHW is examining how to get kids to come in for sealants and how to get better access to those kids. **Representative Rusche** asked for a run chart to see that progress is being made toward that 100% target goal. With regard to the integrated managed care for dual eligible, is that a risk-based plan and is that the problem getting providers to stay or is there another model that may be more acceptable. **Mr. Leary** said that in Idaho, looking at only 22,000 lives potentially, and splitting that up between providers, it is tough in those small volumes to look at that and determine how to spread the risk. DHW is willing to look at alternatives and at all accountable systems of care.

Senator Vick asked about the term "dental home" and **Mr. Leary** replied that it means the provider has a dentist that takes care of these children below three years of age, and he agreed to confirm that for accuracy. **Senator Vick** said he had been told that one provider for managed care is not sufficient, and he asked if that was true; if true, what is being done to address that. **Mr. Leary** said that is true, at least from the Medicaid side; the federal government is pretty clear on free choice of provider. You can have a single provider for managed care, but you cannot make that mandatory. Alternatives are being developed to the managed care program, done on shared risk and savings standpoint, or full risk standpoint as well.

Mr. Leary then updated the task force on Idaho's State Health Care Innovation Plan (SHIP) project, and stated that in March 2013, the Center for Medicare/Medicaid Innovation awarded a six-month planning grant to Idaho to develop SHIP with the goal to promote government-sponsored, multi-payer healthcare delivery and payment models with broad stakeholder engagement to achieve delivery transformation.

Mr. Leary informed the task force that all benefit modifications in HB 260 have been fully implemented and are incorporated in the Medicaid SFY 2014 appropriation. A detailed progress report was sent out in June 2013. Two line item requests for provider rate increases were implemented in SFY 2013 and are incorporated in the Medicaid SFY 2014 appropriation. The hospital assessment, the nursing facility assessment and intermediate care facility assessment used to augment the Medicaid trustee and benefit budget had sunset provisions in statute and are no longer in play.

Co-chair Cameron commented that the initial round of complaints heard on some changes implemented in HB 260 have all died down or gone away, and he asked if DHW agreed with that; **Mr. Leary** said that was absolutely true.

Representative Rusche said he thought a large number of the changes were in the developmentally disabled population and behavioral health services, so with the change to the managed care program and vendor, this is still in flux as far as seeing what changes have done to the population of Medicaid

individuals. **Mr. Leary** asked if this was to do with outsourcing and **Representative Rusche** said his comment was about the complaints about HB 260 dying down and the significant number of changes may be obscured by the fact that DHW is changing to a new vendor in behavioral health services. **Mr. Leary** clarified that would not be a HB 260 change, but rather a new change going to managed care. **Representative Rusche** asked about the changes with regard to both HB 260 and managed care, as well as in SHIP, should we follow that. Will there be changes in the population and how is it assessed whether those changes are good or not, in the overall health of the population? **Mr. Leary** answered that DHW must make sure they get good data. They have that for Medicaid and he is pleased with what DHW provides through the new MMIS system which is the proven part of that system. How that can be looked at for the entire Idaho population is really a pivotal question, he said.

Representative Luker asked about the impact on Medicaid funding with the assessments. **Mr. Leary** said he thought it had no impact, having taken that into account in the appropriations. **Co-chair Cameron** added that the sunset came at a time when the numbers were dropping off dramatically, so there probably is an offset, and the assessment was not needed because the numbers were not reducing dramatically.

Mr. Leary ended his presentation by showing a slide on the Medicaid Eligibles Experience and he invited **Russ Barron** to join him at the podium for his expertise in this area, if there were questions. His slide showed the following:

- SFY 2012 – 227,418 start eligibles – 236,111 end eligibles – 3.9% change
- SFY 2013 – 236,842 start eligibles – 241,496 end eligibles – 2.0% change
- SFY 2014 – August 242,076 - 1.5% annualized

Co-chair Cameron asked for a comparable sheet showing actual enrollees and not just eligibles and **Mr. Leary** clarified that the above numbers were enrollees. **Co-chair Cameron** then asked if the above numbers were the people participating in Medicaid during those years, and **Mr. Leary** affirmed that the slide should say "eligible participants enrolled in Medicaid."

Senator Hagedorn asked how the percentage change correlates with population growth of the state and **Mr. Leary** said he didn't have that information, but DHW will look at that and get that data to the task force. **Co-chair Cameron** asked how this growth compares to other programs that are being offered through DHW. **Mr. Barron** answered that the big one is food stamps, the other being Medicaid, adding that there is a decline, seeing a steady small decrease month-to-month. He didn't know if that information could be correlated. **Co-chair Cameron** asked to what the reduction in Medicaid growth is contributed. **Mr. Leary** said the bottom line is the economy, and as the economy gets healthier, people go off Medicaid.

Representative Rusche commented on the woodwork effect and asked what difference that makes as far as DHW's ability to handle the load and as far as other aspects of low income healthcare costs for indigent, CAT fund and charity care in hospitals. **Mr. Leary** answered that during last year's session, it was estimated to be an average of 14,000 lives coming on through the woodwork effect, during the last six months of this fiscal year, so that was built in, months covered on average through those years. **Mr. Leary** thinks DHW is prepared to take care of that and there is an impact on the personnel side, and he

allowed **Mr. Barron** to address that. **Mr. Barron** confirmed that his division had been hit with lots of questions for over a year. There is confusion, and some people thought that Idaho did expand Medicaid. With regard to the woodwork effect, **Mr. Barron** believes they are okay at this point. **Co-chair Cameron** said there were two hits to Medicaid as a result of PPACA, and he asked how many of those 14,000 coming on did he attribute to that piece versus how many to the fact that they have to have some level of coverage. **Mr. Leary** said that the impact from the MAGI essentially went away during session when they got updates from CMS that it was a zero sum gain and so all these are due to the woodwork effect alluded to earlier. Individuals are out there, eligible for Medicaid, but because they start showing up at the insurance exchange, they get identified and sent to Medicaid. **Co-chair Cameron** asked about the flattening of the Medicaid population up to now, wondering if any of that was contributed to the change in the eligibility system or the change in the Molina system. **Mr. Barron** replied that he doesn't believe there is an impact due to those systems. The systems are running fine and he didn't think there was any issue before or now to make this kind of an impact.

Representative Luker asked why the ending number for 2012 would not be the beginning number for 2013 with regard to Medicaid eligibles and **Mr. Leary** said he took these numbers off the eligibility report and he started on July 1st thru June 30th and admitted the figures to be slightly off, adding that there are twelve months in both periods.

Representative Rusche asked if there had been any movement or new suggestions from either DHW or the Governor's office on how to address the lower than 100% federal poverty level, Idahoans who are not currently eligible. **Mr. Leary** answered "no."

Senator Hagedorn said that PPACA was supposed to have coverage for everyone and he now wonders about those people below the 100% federal poverty level. **Co-chair Cameron** affirmed that PPACA has a "loophole or donut provision" where individuals below 100% poverty, but not eligible for Medicaid, don't get help from either, but they can use the exchange and buy insurance. However, if they are 101%, they would get federal assistance and if 99%, they would get no help. That is partially because the act is drawn with the provision that states would be forced to expand Medicaid and the Supreme Court ruled that states could not be forced to expand Medicaid, so that decision has not been made by Idaho as yet. **Senator Hagedorn** said that since there are no negotiations in D.C., that's not on the table to be fixed as well, asking if that was correct. **Co-chair Cameron** said that was his guess.

Representative Rusche asked if it would be beneficial to this task force to have a report on what the Medicaid plan and the Governor's office has been doing with CMS around the issue of 80,000 Idahoans who are falling thru that "donut hole." **Co-chair Cameron** said he would take that under advisement, adding that he wasn't sure that would be discussed this year and that he would not be comfortable asking the Governor's office what they had been doing, but agreed that this task force could discuss this issue. Anyone desirous of bringing forth a proposal can do so, he added. **Co-chair Cameron** did say that various entities, organizations, counties, hospitals, etc. will be willing at some point to share their ideas on this issue, and this task force will be willing to listen.

Next on the agenda was a panel discussion about proposed rate increases for 2014 individual insurance plans, since it became apparent to **Co-chair Cameron** as it got closer to October 1, carriers all had to

produce rates for 2014. Normally rates would be distributed 30 days in advance of the next period and would change typically on a quarterly basis. PPACA has changed that methodology completely, he said, so he turned the podium over to **Mr. Paul Harmon**, Regence BlueShield of Idaho, inviting him to inform the task force on how difficult it is to project, going forward. **Mr. Harmon** said he was an actuary for Cambia Health Solutions, responsible for individual and small group filings for 2014 in Oregon, Washington, Idaho and Utah. He said Idaho was impacted more than other states and PPACA created a whole new world and information became currency. DOI was very good in setting expectations and sharing information, giving guidance and direction. Hurdles included not being sure what the population will look like on January 1, 2014. They face significantly different benefit designs and coverage, and a different approach on how to set premiums. Now the focus is on age and where a person lives, and rates are set based upon that. It doesn't necessarily raise the cost of the pool of members overall, but it can make a huge difference for individual people. Previously, if healthy, a person had a fairly low rate for health insurance; that choice will become bigger under PPACA where health status does not benefit a person's premium. It won't raise costs overall, but makes a huge difference from member to member. The other major Idaho impact is around the benefit coverage, previously having flexibility on what was covered in a plan and how much coverage there was (i.e. maternity and drugs), deductibles and out-of-pocket costs. On average, your benefit will cover more for you, and more may have to be paid on the premium, with less out-of-pocket expenses throughout the year. The total package is more comprehensive than it used to be. Part of what goes into coverage includes taxes and fees to support the reinsurance program for individuals, and that is a very important program. Regarding the rating, historically a block of business could be looked at to project forward and make assumptions. With PPACA and the risk adjustment program, rates are being set to a market average and each carrier doesn't know what other carriers are going to do, or what costs and structure will look like, so assumptions have to be made when consumers are faced with new choices. When the enrollment and experience come in, plans for 2015 must be made almost immediately.

Mr. Jack Myers, Blue Cross of Idaho, was the next panel member and he said that through the spring, the rigorous process took place, reviewing a variety of assumptions to try to select across a broad array of issues what their position would be on each assumption. They tried to understand the population of 100,000 currently insured through individual policies. They are expecting those people to continue to buy insurance, but some younger and healthier may see some rate increases and decide it's not worth it to remain insured. Those who are older will find coverage to be more attractive. **Mr. Myers** said he is expecting that the majority will continue to be insured, but for the roughly 270,000 uninsured, it remains a much bigger question trying to understand their thinking about whether to buy insurance or not. As rates are set, at the very end of the process, it becomes unclear how to address the uninsured potential members going in. In Massachusetts, roughly 30% of that population signed up the first year, but that was at no cost to those people, and there certainly is cost to those who might sign up this year who are uninsured. Those less healthy will be more inclined to buy and vice versa, and lower income people may buy due to subsidies and those beyond 400% of current federal poverty level would be less inclined to buy. Those are all challenges, trying to understand what the risk characteristics are of that population, relative to the population being currently insured. Federal taxes and fees get added into insurance policies. The biggest part, the excise tax, is highly dependent upon how many people enroll. The more who are insured, the lower that rate is per individual, so the right amount to add in is an estimate. It will take about three years into PPACA to get to a period of stability, with many assumptions being made

currently. **Mr. Myers** is comfortable with the rates that Blue Cross came up with as best estimates to reflect what the real costs of that population will be, but uncertainties remain.

Co-chair Cameron explained that Blue Cross was a bit unique from Regence or others because Blue Cross has grandfathered plans, having policyholders who will choose to stay with an existing plan and not be part of the exchange or the new system and new rates. Did that make it easier or more difficult for Blue Cross to project into the next year? **Mr. Myers** replied that it didn't make the process any easier, still having to consider all the same variables to come up with a rate that would be applied for the entire individual policyholder population. There are about 17,000 of those people, but not all of those will stay grandfathered, since they may find a policy less expensive on the exchange.

Co-chair Cameron asked about the uniqueness of Regence and the decision to start a separate company to participate inside the exchange called BridgeSpan. He wondered if Regence will still market products outside the exchange and BridgeSpan products inside the exchange; he asked how the actuarial assumptions affected that differential. **Mr. Harmon** said that for Cambia, Regence has an affiliated carrier called BridgeSpan introduced for exchange business and they wanted a company to excel at this new way of life in the insurance market. From the assumption side, how the PPACA works is that you can't really differ assumptions that greatly between affiliated carriers to try to prevent gaming the system. Therefore, assumptions for BridgeSpan and Regence had to be largely identical except for a few very specific differences in networks, provider options or exchange fees, but even those were spread amongst carriers in Idaho, so there was a very similar approach to each. **Co-chair Cameron** commented that when rates were submitted to DOI and were approved, nobody wanted to be the first one to release rates. What if the assumptions are too low or too high? **Mr. Harmon** answered that if rates come in too low, so that costs are above what is being charged, the following comes into play: (1) risk corridor which mitigates losses up to a certain extent; (2) risk adjuster could come into play, if one carrier had gotten more of the risk than expected, and there is a payment mechanism where carriers would transfer money amongst themselves to offset that higher risk that a particular carrier might have had. Those help mitigate losses but don't necessarily remove them, in which case the premiums may cost more in 2016. If the premium was more than necessary, risk corridor and risk adjustment come into play. Money could be paid back to the federal government to limit profits or the minimum loss ratio requirement could come into play, returning some premium to policyholders with future rates probably being less than they otherwise would have been. **Co-chair Cameron** asked when rates had to be submitted for 2015 and **Mr. Harmon** said the best guess today would be the end of May, with only five months of experience. **Mr. Myers** commented that it would be five months to the date they would expect to be filing but, at most, there would be only three months of estimates, since claims really aren't in yet, so very little actual claims experience, perhaps only 1-2 months of actual data.

Representative Rusche asked if the decision to not expand Medicaid last session changed the assumption and calculations on plans for either this year or 2015. **Mr. Myers** answered that the decision not to expand would mean that those people below 100% would not be eligible for Medicaid and would also not come into the exchange, so that population between 100% to 138% would be eligible to come onto the exchange, so it affected rates to the extent that it was looked at as part of the population that would be eligible. Instead of moving into Medicaid, that portion of the population is eligible to go through the exchange and receive subsidies, so that is the way rates were affected. **Representative**

Rusche said he was concerned about the cost shift, especially since Cambia/Regence has the ability to observe states that have expanded coverage for low income people. He asked if that cost shift rated into the premium. **Mr. Harmon** answered "yes." He explained that people currently receiving insurance coverage tend to be high risk, so having some of those members leave the insured market for Medicaid expansion helps out the commercial market. That population is fairly small, so the overall impact is not that great to the rate level, but it puts more cost into Medicaid and less cost on the commercial side.

Mr. Dave Self, PacificSource, was invited to give his input. **Mr. Self** said that he was not an actuary, as were the other two panel members. He said that PacificSource started with a simple formula that was conservative and based on the normal rating process, stripping out age, risk, and gender. Then they looked at market morbidity, which was the biggest shift in thinking, including the current insured population as well as the uninsured, as well as people on COBRA, the high risk pool in Idaho and federal high risk pool (PCIP). All of those categories receive a weighting with a value and they took into consideration how conservative their organization is. The Society of Actuaries pegged Idaho with a weight of about 60% over a year ago, ranging from 15% to weighting morbidity to about 30%, and PacificSource was on the higher end of that scale. They are not the least expensive plan, by design, and they are rating not just for 2014, but for several years, not knowing what enrollment in plans will actually be. He believes that things will settle down in 2016 and all markets will begin functioning properly and there will be a clearer idea if the bet placed on rating methodology was the proper bet.

Co-chair Cameron asked if there were any second thoughts, after the rates rolled out, pointing out that out of the three companies represented in this panel, PacificSource's rates are on the higher end, Blue Cross is on the lower end, with Regence in the middle. Even though planning for the long-term, there is the risk of individuals going to the exchange who may shop for the lowest price and the population may diminish as renewals come into play, asking if there was concern about that. **Mr. Self** said there was concern, but he believes over the long-term a number of factors will play into this market. He said this was not about PacificSource, but rather about creating a competitive marketplace for consumers in Idaho. **Co-chair Cameron** asked if there was any concern from Blue Cross and **Mr. Myers** stated that the range of the values for each assumption can be fairly broad, the market morbidity the best informed estimate of that, so Blue Cross believes that the rates reflect the best estimates for now and they are not expecting to see significant price changes in 2015. There are things inherent in PPACA that will cause prices to increase over time, including the excise tax increasing from 2014 to 2015, and the reinsurance program as it phases out over a three-year period of time. There is a $5.25 fee that carriers pay for that, but the benefit of that program is great. He expects something greater than normal trend in price increases over the next few years. He does not have concern that Blue Cross missed the assumptions by a broad amount. **Co-chair Cameron** wondered if three years was long enough on the reinsurance program, since the rate adjustments will not be seen until 2016 and there will be lagging indicators.

Co-chair Cameron asked to what extent did the potential of the premium assistance program that will be available through the exchange, or the tax credits, come into play in the development in determining rates for each of the three panel member's carriers. **Mr. Harmon** replied that it had a big impact, but said it was a hard thing to lock down. He said this comes into play in two areas, those being healthy individuals currently insured who will be expected to provide much more subsidy for their peers and how much of that higher premium will that person have to pay individually versus the federal government. If the

subsidies line up correctly, those individuals will stay in the pool and help maintain overall costs. The more unknown piece is with the uninsured population. Right now, in a flexible Idaho rating system, people have chosen not to have coverage; going forward, those costs are higher for most of them than they are today, so the default will be if they sign up and the income level of the uninsured population. In extreme cases, insurance could be free. If communication is there, they will enroll, so that affects the morbidity adjustment and how much of the uninsured will enroll and how many currently healthy insured individuals will leave, given the new world. **Mr. Self** said that there are several factors relating to the question, one being the psychology of the buyer, which is unknown, and PacificSource took the conservative approach. As to the morbidity concept, over time things may normalize and he thinks the rates looking forward will be a better target for PacificSource and they are comfortable with that assumption.

Representative Luker asked if there were other ways to compete. Would there be other options besides generic coverage with essential health benefits and if there are add-ons in order to compete more than other companies. **Mr. Self** replied that there is a moderate range of differentiation to try to affect within the exchange environment and he doesn't believe PacificSource has maximized those on the first go-around. They have moved to coordinated care networks within the exchange, the base products being offered, working closely with health systems, regional medical centers, and IPAs around Idaho to create systems where the consumer can maximize the value of care and the fluctuation can be minimized in experience over time. He said the big differentiator is more of a coordinated care network, maintaining high quality care, and mitigating the cost increase over time. PacificSource offers other ancillary products as well. **Representative Luker** said that the price point will be a big issue on the exchange and he was trying to figure out if benefits can be explained to the potential customer in the exchange. **Mr. Self** believes that if a side-by-side comparison is done, he thinks PacificSource has stronger benefits from the consumer perspective than competitors and that is a strategic decision that each company makes.

Representative Hixon asked about year-to-year increases in cost for insurance, and with PPACA, huge increases have been seen in a short period of time, asking if loss ratio projections show any leveling out or decreasing at some point in the future, or will 8-15% increases year after year be seen. **Mr. Myers** said he didn't think there was a lot in PPACA that changes the underlying primary drivers of the healthcare cost trend that makes up about 90% of the overall premium rate. There has been a reduction in the overall healthcare cost trend over the past 4-5 years, concurrent with the economic downturn, and the jury is out as to why. The underlying increase in insurance rates may continue on in the future until the underlying provider cost changes can be addressed. All plans are trying to work with providers to bring costs down through coordinated care activities, changes in how providers are paid with an efficiency and quality metric as opposed to fee-for-service mechanism, so programs are in place and this will take time. He thinks there will continue to be some increases, perhaps more moderate than in the past, but cautioning that some features of health reform are being phased out and with increases in excise taxes, there will be an increase as a result. **Representative Hixon** asked what provider cost is the most significant driver or does a specific sector drive rate increases, or is that spread across the board. **Mr. Myers** said that hospital costs, both inpatient and outpatient, have been much lower and that great improvements in providing care keep people out of inpatient stays. The largest increases have been in the hospital outpatient sector, some being due to technology. Physician costs and utilization have remained fairly stable. A huge segment of healthcare costs is specialty pharmacy costs and new biologics coming out which are very costly. **Mr.**

Self added that PacificSource does business in three states, each one having its own profile, and in addition to pharmacy increases, he mentioned infusion therapies which are very prevalent and are beginning to be a factor in Idaho.

Mr. Bill Deal, Director, Department of Insurance, was next on the agenda, and he shared that he had just attended a western state conference of twelve states, eight having state-based exchanges and four having federally facilitated exchanges, and he found that Idaho was one that had a good beginning in comparison to others. Idaho was referenced as having lower rates, and he applauded the four insurance companies participating in the Idaho exchange offering competitive rates for Idaho citizens. Health underwriting is no longer a factor, and rates in 2014 will vary only by plan, coverage, age, geography, tobacco use, and whether an individual or family. **Director Deal**'s PowerPoint presentation entitled "DOI Plan Management" is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1007_deal.pdf

Director Deal talked about Idaho's insurance plan coverage including plan management, transfer and issuer preview timelines and QHP certification standards; individual medical market plans; small group medical market plans; individual dental market plans; small group dental market plans; and a summary of unique plan IDs recommended for certification. **Director Deal** said that insurance rates have spread in them, giving an example of a policy for a young man 18-28 with a rate of $80 under today's plan will increase to about $120-$160. He said that female rates were higher, but will be coming down, and there are plans that will keep rates comparable in some cases by some companies. As age increases, rates will come down for both men and women. DOI's plan was completed and all benchmarks were met, so he expressed pleasure about that.

Co-chair Cameron asked if, from DOI's perspective going through rate renewal and projectory rating, does DOI see that changing much, other than being done annually, rather than quarterly or more frequently. **Director Deal** confirmed that to be true, adding that DOI will go through a soft deadline in May to allow companies to work through that process. **Co-chair Cameron** agreed it was a good idea to do a soft deadline for filing with DOI, but it might be a good idea for a hard release date once everyone is approved and everyone releases on an "x" date. **Director Deal** replied that is what DOI had done, holding the release of rates until the second week of September to be certain to guarantee the companies who had filed that there wouldn't be others coming in with lower rates, a maneuver agreed upon by DOI and the companies. **Co-chair Cameron** said at times that DOI was taking the blame for being slow on rate approval, but now he understands that the rates had been approved, but they were waiting for a release date, and that was affirmed by **Director Deal.**

Co-chair Cameron asked how DOI takes into account other state statutes affecting rates in conjunction with the federal PPACA and what that is requiring. Do the two mix? How does Idaho ignore the ramifications of individual market reform and all of those other items and focus strictly on the new PPACA requirements. **Director Deal** answered that statutes set how DOI does insurance business in Idaho for health insurance versus the PPACA. **Co-chair Cameron** said he realized that parts of statutes are superseded by federal law, but there are also parts that specifically tie into developmental rates, renewal, and rate increases. Those would still apply to those grandfathered plans, he assumed, but he asked how they applied to plans not grandfathered. **Deputy Director (DOI) Tom Donovan** came to the

podium and answered that the preemption provisions of the PPACA provide that the ACA does not preempt any state law that doesn't prevent a provision of the ACA from coming into play. Therefore, any direct conflict would be deemed preempted. The Director, he said, had mentioned provisions going forward in 2014 that carriers can use to apply to rates including age, tobacco use, geography, and plan makeup being the limited ones. To the extent that DOI can meld the two, DOI has, an example being geography. The federal regulations say that a state can use up to seven geographic areas, but Idaho Code has six geographic areas, so the 837 zip numbers are within the same rating area as the 836 zip numbers. This is an effort by DOI to still enforce Idaho provisions that would apply and are not preempted, in DOI's view, but also eliminates some provisions allowed previously by Idaho law such as gender, health history and pre-existing condition, for example. DOI tries to enforce Idaho provisions, when able, to not have the preemptive effect. **Co-chair Cameron** said he thought there was a provision in Idaho law that requires that increases not exceed 15% plus trend, asking how that fits with the difficulty that carriers are now facing, since some are going up more than that. **Mr. Donovan** replied that there is a rule that contemplates a person's health history, so he didn't think DOI had tried to apply that limitation, given the wholesale fundamental change in rating under which carriers must operate, going forward.

Co-chair Cameron wondered what DOI's role was, moving forward, into 2015 and 2016 as the carriers develop rates, asking if that would change. **Mr. Donovan** answered "not at the present time." He thinks that DOI's role is to apply the law as it exists, obviously with changes that might impact that. **Co-chair Cameron** asked about a carrier that decides to be very aggressive in the marketplace and it looks to DOI like it would potentially damage the marketplace or the carrier itself, what would DOI's actions be. Also, if the carrier is potentially charging too much and DOI sees that could result in a refund back to the consumer, what action would DOI take. **Mr. Donovan** answered that the way the ACA is set up and the rules have come out for the refund issue for the medical loss ratio, the federal government is not seeking to defer to the states. He said due to the detailed financial reporting that states collect, states are working with industry to help carriers accurately report information that goes into the MLR equation, because previously it hasn't been collected or at least reported so that it matches up exactly. There is not a direct way to look at an approved form that carriers file with DOI that identifies the MLR ratio and the way to calculate a refund. He thought there was less of a role in terms of DOI if they thought a carrier was charging too much, potentially providing a refund to small group or individual members. **Mr. Donovan** said that Idaho is much closer to wanting to have a lighter regulatory touch to allow the market to play out and let the carriers experience rates. If a carrier gets into hot water, the DOI Director's authority would be much greater, having tools to help maintain solvency. Those types of issues would play out based on facts, he said, and discussions could take place, financial information can be tracked and DOI has the authority to send in examiners on a regular basis. **Director Deal** interjected that rate adequacy is an important part of this formula, so DOI doesn't want carriers to undershoot the market or be in excess of what is needed, and he thinks the medical loss ratio will play a big part in evening this out.

Representative Luker asked about the zip codes and if those divisions allow for geographic risk rating and **Director Deal** answered that he calls those seven geographic areas the community rating factor. **Representative Luker** wondered about the listed plans, asking if someone could pay more in one area than another due to the area rating for the same plan, and **Director Deal** affirmed that to be true. **Senator Hagedorn** asked for clarification about the open exchange and asked if there was something like a closed exchange. **Director Deal** replied that there are two operations. With the federal exchange, it is

basically a closed exchange and several companies are allowed to sell a product in the marketplace. Idaho took the open exchange route, meaning that companies can participate if that company has authority to sell health insurance, is licensed in Idaho, and will follow the guidelines of the products listed on the exchange, so Idaho ended up with four good companies, making this a better marketplace. **Senator Hagedorn** asked about page 5 of the presentation showing Blue Cross plans, as an example, saying that the bronze plan for zip code 832 had three choices, and he wondered why a company would have three of the same plans. **Director Deal** said that there were different options inside deductibles, co-pays, etc., adding that there are those types of differences between the plans.

Co-chair Collins asked how to explain to policyholders who had an existing policy, perhaps not grandfathered, having received a notice from the insurance company that their current plan does not meet specifications and, as a result, that policy must be changed, even though nothing has changed in the life of that policyholder. When they go to replace that policy, they are told that the increase in premium is 100% or higher for a lesser benefit, and he asked how that can be justified. **Director Deal** said the first answer is that some companies are still sending out new policy renewals at today's rates, using as an example a family member having a family of three and the rate went up $107, bringing the total to $800. A new rate could be shopped on the Your Health Idaho marketplace, and he suggested that his family member could find another policy for $107 less than previously paid. **Director Deal** said that DOI has worked very hard with producers to get to be the front-line provider of information for citizens, since he is convinced that if you get on the web to shop for comparisons, products are available, but citizens will need help moving forward. He is very thankful that agent groups and associations have worked hard to be the navigators, since it's all about communication.

Co-chair Collins asked one of the actuaries to interject on the subject of an existing policyholder having a policy renewing in November, asking what rate is that citizen being quoted, what is advertized on the exchange or is there a different set of renewal rates. **Mr. Harmon** said that policies renew every month of the year on a regular basis, so throughout the rest of this year, anyone having a policy renewing on October, November or December 1st can get the plan renewal for the "old style policy" for one more year. On the anniversary in the subsequent year, 2014, then that policyholder will have to get an exchange product, unless they are grandfathered, then they can stay on longer. **Co-chair Collins** wondered if the renewal rates for the existing plans are based on a different actuarial summation than what is put into the exchange. **Mr. Harmon** replied that the renewal rates for the individual and small group policies would be based on the quarterly filings, so quarterly rate increases are filed for those two populations, and that would not include all of the changes that must be adopted as of January 1, 2014, for healthcare reform.

Co-chair Cameron said that one problem he has seen is with regard to a larger family; PPACA charges a per-child rate whereas previously there was a one-child rate, or two or more rate.

Senator Vick asked why there are almost no platinum plans offered. **Director Deal** replied that the platinum is the richest of all plans, with an actuarial value of 90%, having the least out-of-pocket expenses, with richer benefits. As far as the exchange is concerned, most companies felt that the benchmark plan is the silver plan, so that was the choice of many companies. **Senator Vick** asked about the 15% plus trend, asking if that was in law, and **Co-chair Cameron** answered that was in state statute.

Senator Vick asked about flexibility because of all the changes; he said that DOI chose to ignore that, asking what ability DOI has to do that. **Director Deal** answered that the 15% applies to health conditions, and increased health problems could not be rated more than 15%. In the rates for January 1, 2014, there is no health issue condition, so there will be no health criteria as of January 1, 2014, and that is the reason that it's not going to be followed, due to that change and how rates will be computed.

Representative Luker said that in his experience it seemed that insurance policies have generally been an 80/20 standard. Now there is a wide variety, and he asked if any different ratios are expected or are people buying more 70/30 or 60/40 policies than 80/20, the end result being less coverage for more money. **Mr. Myers** answered that he thought 80/20 co-insurance has been popular, more on the employer side, than for the individual policyholder. The most popular products for the individual are the cheapest policies. If left to the individual, they will choose a lower benefit plan, either through a higher deductible or a lower co-insurance. He believes that behavior will continue. **Co-chair Cameron** said that the big unknown is if a person qualifies for a tax credit, will that person choose a richer benefit, adding that nobody knows how that will play out. **Director Deal** expressed concern about the bronze policy which is 60/40, which is going to be the least expensive, but also means more out-of-pocket money, which people may not have. This could be detrimental to doctors or hospitals if there is a big procedure, so maybe the subsidy could help some move up to a richer plan. **Co-chair Cameron** said there is cost-sharing assistance for a person based on income and there is the tax credit, a premium, one being tied to the silver plan and the other not.

Senator Hagedorn asked if the policy costs that all the companies have on the exchange are visible to the other companies and how will that impact next May's submission for policies. **Director Deal** said that rates are listed on the website by age, and it's public record, that being the reason the rates were held until the second week of September, and DOI will do the same this year as the rates are computed.

Representative Wood said that he had not been on the website but he commented that unless you actually sign in to create a profile, information is not available, and he believes this to be wrong. He thinks this information should be available up-front and visible to everyone for comparisons with one mouse click on the website. He suggested the board discuss this issue, believing this would create more interest than anything else. **Director Deal** agreed that is a complaint that DOI has heard, saying that people want to shop and not have to buy, that being the issue.

Senator Schmidt asked about Joy Wilson's suggestion as to informing seniors about scams, asking if DOI was working on that. **Director Deal** said that DOI's last news release was on September 10, listing scams in northern Idaho. He informed the members that scammers scare seniors by telling them that to get renewal of a Medicare card that information must be given out, and he believes this will get even worse. **Co-chair Cameron** cautioned that people had been called about a survey on the exchange, and he encouraged DOI to double efforts to advertise so that people will not be taken advantage of. **Director Deal** assured everyone that DOI was working on this, as well as the Attorney General's Office, adding that they are working together on this issue of scams.

Co-chair Cameron announced that the Health Care Task Force will meet again on November 4th and December 9th, 2013. The meeting was adjourned at 4:25 p.m.