MINUTES

*(Subject to Approval by the Task Force*)

Health Care Task Force
December 9, 2013
Capitol Building, Boise Idaho
East Wing, Committee Room 42

In attendance were Co-chairs Senator Dean Cameron and Representative Gary Collins; Senators John Goedde, Patti Anne Lodge, Steve Vick, John Tippets, and Dan Schmidt; Representatives Lynn Luker, Brandon Hixon, Luke Malek, John Rusche and Elaine Smith. Senator Marv Hagedorn and Representative Fred Wood were absent and excused. Legislative Services Office (LSO) staff members present were Ryan Bush, Jared Tatro and Charmi Arregui.

Others present at the meeting included Tim S. Olson, Idaho Academy of Nutrition and Dietetics and Nez Perce Tribe; Dick Armstrong, Paul Leary, Cynthia York, Wayne Denny, Denise Chuckovich and Elke Shaw-Tulloch, Department of Health & Welfare; Tom Donovan and Bill Deal, Department of Insurance (DOI); Ken McClure, Idaho Medical Association; Emily McClure; Dave Jeppesen and Julie Taylor, Blue Cross of Idaho; Kathie Garrett, National Alliance on Mental Illness (NAMI); Shad Priest and Lyn Darrington, Regence BlueShield; Woody Richards, Attorney/Lobbyist; Larry Benton and Kris Ellis, Benton & Ellis; Amy Dowd, Your Health Idaho; Elli Brown, Veritas Advisors LLP; Corey Surber, Saint Alphonsus; Toni Lawson and Steve Millard, Idaho Hospital Association; Nathan Andrew, Emergency Medicine of Idaho (EMI); Vivion Maisenbacher, Mylan, Inc.; Parrish Miller, Idaho Freedom Foundation; Tom Fronk, Idaho Primary Care Association; John Foster, Kestrel West; Kurt Stembridge, GlaxoSmithKline; Lisa Reed, Delta Dental of Idaho; Dr. Kendra Witt-Doyle, Blue Cross of Idaho Foundation for Health; McKinsey Lyon, Gallatin Public Affairs; Marnie Packard, PacificSource; Bibiana Nertney, Community Partnerships; Larry Tisdale, Idaho Hospital Association; Stacey Satterlee, American Cancer Society Cancer Action Network; Christine Pisani, Idaho Council on Developmental Disabilities; Elizabeth Criner, Pfizer, Idaho State Dental Association; Starla Higdon, Treasure Valley Food Allergy Network; Alicia Jordan, School Nurse Organization of Idaho; and Dr. Ted Epperly, Family Medicine Residency of Idaho. Austin Bordelon and Dan Schuyler, Leavitt Parners, participated via telephone conference call.

**Co-chair Cameron** called the meeting to order at 9:03 a.m. He called for approval of the November 4, 2013 Minutes and **Senator Schmidt moved that they be approved, seconded by Senator Lodge and the motion carried by a unanimous voice vote.**

**Dr. Ted Epperly**, Family Medicine Residency of Idaho, was the first presenter who gave an update on the Statewide Healthcare Innovation Plan (SHIP). His PowerPoint presentation can be found on LSO's website at:
**http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_epperly.pdf**
**Dr. Epperly** said that the Commonwealth Fund about five years ago said that there are two things that change the health of a population: (1) having some sort of insurance coverage, and (2) having a usual

source of care. These two things when coupled start to really help people's health improve and the population's health improve. Multiple things are happening in Idaho to help with coverage including the Idaho Health Insurance Exchange, contemplation of Medicaid expansion, to people having insurance either on the individual market or through employers. This whole concept is all about the second part of the equation which is what is being done to make sure that as many people as possible have a usual source of care, a place to go for care, and then to align payment with that to make the whole thing work. **Dr. Epperly** shared a brief history of how Idaho has redesigned its healthcare system. In March 2013, Idaho was awarded a planning grant to develop SHIP and its goal was to design a model that evolves Idaho's healthcare delivery system from a fee-for-service, volume-based system to a value-based model of care based on improved health outcomes. The SHIP planning grant is managed by the Department of Health and Welfare (DHW) who contracted with Mercer Consulting to provide process facilitation. The SHIP steering committee acted on recommendations finalizing plan design to be submitted in early 2014. This model testing funding opportunity could result in significant federal funding to assist Idaho in implementing SHIP. The rollout of the multi-payer payment model would be a phased rollout over five years. The implementation grant will come out in January 2014. **Dr. Epperly** said that the state and SHIP stakeholders are committed to continuing healthcare system transformation, regardless of receipt of funding, because it's the right thing to do for Idaho.

**Senator Goedde** said that it appeared that the focus is on primary healthcare and establishing a medical home. In Idaho there is a shortage of general practitioners, assuming that is who would be in charge of primary healthcare. Part of the reason for this is the disparate compensation through use of conversion factors for specialists, and he asked about that. **Dr. Epperly** said that Idaho ranks last in the U.S. in the number of primary care physicians per capita and to get this model to work, we must have places for people to go for care. Idaho is starting to roll out an expansion of its workforce and we also need to make better use of nurse practitioners and physician assistants as well, but this will take many years to see progress, but a plan must be in place. **Senator Goedde** said it sounded like in twenty years perhaps the state will need less subspecialty practices. **Dr. Epperly** said that perhaps the state will need a different proportion. Currently in Idaho and across the nation there is about 70% subspecialists and 30% primary care physicians and that mix should be closer to 50/50.

**Representative Hixon** asked about the sixty meetings held by stakeholders and the discussion of healthcare pricing transparency. **Dr. Epperly** said that transparency for consumers is a big deal and there is not enough of it. Many healthcare costs are hidden, and **Dr. Epperly** believes there needs to be a standard price for procedures so that comparisons can be made by consumers for informed choices. **Representative Hixon** asked about the per-member, per-month fee on top of current costs and how can lower costs result with SHIP. **Dr. Epperly** said that the personal email or phone contact he has with patients can reduce costs versus trips to his office or the emergency room. That per-member, per-month fee starts to pay for integration of care to keep patients healthy in a different model of care and costs insurance payers less. Lower premium costs are the result for employers or individuals.

**Representative Rusche** asked about data aggregation for population management; how do you envision that happening and how does the SHIP process bring that along? **Dr. Epperly** said that practices need to

enter data in a de-identified way, so as to not violate HIPAA regulations, and that data flows up to the health data exchange, a central warehouse of data. Payers can see that data, as well as physicians, and that can be used for analysis and comparisons so that best practices can enter in. **Representative Rusche** said that significant consolidation has taken place and **Dr. Epperly** said that consolidation will be good by integration and coordination of care across primary care practices and subspecialists. If hospital services are needed, they have outreach but there are still "roads" that need to be built so that all data can be accessed. Telehealth and telemedicine can also connect specialists with patients in offices and their homes to provide the highest quality of care as close to home as possible. Integration and coordination can happen both within a closed system, within hospitals or by a private physician's practice. The payment system needs to be aligned to value that, so the patient doesn't have to drive long distances for care. The implementation grant is for three years, but it will take much longer for this process. However, it will jump-start the entire healthcare system; the ultimate goal is for better health, but it will also bring down costs.

**Senator Schmidt** thanked **Dr. Epperly** for developing this vision, and he asked if the steering committee envisions any statutory changes from the legislature. **Dr. Epperly** said that this has been discussed with Senator Heider and Representative Fred Wood about how best to go about this. He said that they may need guidance and advice on this, but for now he asked that the legislature stay supportive of the concept, adding that input was always helpful.

**Senator Vick** asked about the amount of paperwork and if the SHIP process will help that. **Dr. Epperly** said yes, by having data flow electronically and simplification of the payment system on the insurance side. Having an integrated and coordinated system should help with the paperwork burden.

**Co-chair Collins** asked about the model testing grant and asked for more information on that. **Dr. Epperly** said that the six-month report card will be turned in at the end of December 2013, and that will be used as the nucleus for the model testing proposal amounting to $40-60 million, a 3-year grant, and governance would be set up. The regional collaborative would be developed, robust primary care and facilitation of practices would start, and the build-out of the Idaho Health Data Exchange and the information systems would happen. Quality proposals would be built in and work would continue with payers. That is how that money would be utilized. DHW would be the initial location of the rollout and then a spinoff would occur during that next three years. Ideally, all of this will be built to be sustainable so that when that money stops, benefits from the system will keep it intact. North Carolina has been able to do that since 1997, and that is why that model was studied.

**Representative Luker** asked about subspecialties and the capitation rate and **Dr. Epperly** replied that the capitation and the different system build-outs on savings are primarily looking at how primary care can function better. The idea of the blended payment is a horizontal model across primary care.

**Co-chair Cameron** asked to what extent the committee was working with other state agencies or entities with regard to state employee benefits. **Dr. Epperly** said they are not working as much as they need to, at this point; clearly, most of the effort has been with DHW, and DOI has been engaged in some

capacity with insurance companies. However, nothing has been done with the Department of Correction at this point. The model being developed can be used for any entity. It was confirmed that one requirement of the grant will be to integrate state employees into the SHIP plan.

**Mr. Richard Armstrong**, Director, DHW, was the next presenter and his PowerPoint presentation is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_armstrong.pdf
**Director Armstrong** gave the task force an overview of Arkansas's alternative plan to Medicaid expansion and how it relates to Idaho. He said he was an avid student about what is going on in other states, and Arkansas has similar parallels to Idaho, although Arkansas is running a federally facilitated exchange. The Arkansas Health Care Independence Program or the "Private Option" uses a free market approach instead of expanding the traditional Medicaid program. It purchases qualified health plans from the insurance exchange for low-income adults who are not eligible for Medicaid. It uses federal dollars to pay for premiums. It is approved by the Centers for Medicare and Medicaid Services (CMS) as a demonstration project, meaning it is a pilot project that cannot cost more than traditional Medicaid coverage.

Idaho has 1.6 million people with median household income of $46,900, adult uninsured = 25%. Idaho projects 104,000 uninsured adults under 138% of poverty. Arkansas's private option eligibility is for people with incomes below 138% of poverty, $15,860 for single adults, and $32,500 for a family of 4. Eligible participants shop in the portal to select and enroll in a high quality, affordable health plan that meets their specific needs at a competitive price. The state pays insurer directly for premium costs; premium payments are 100% federally funded until 2017, at which time the state begins paying a 5% share. The state share of premium costs increases in subsequent years, capping at 10% in 2020. Plans are silver metal level; there must be an option of two plans for participants to choose from. Medicaid required benefits that are not offered in eligible QHP plans are supplemented through the existing Medicaid program framework. This includes non-emergency transportation and EPSDT (early and periodic screening, diagnosis and treatment) for adults under 21. Idaho's state-based exchange could require supplemental benefits, and further study would be necessary.

Arkansas has 80,413 applications filed; 68,692 have been determined eligible, 58,591 have completed enrollment, and the difference remaining are still in the eligibility determination process. **Director Armstrong** pointed out that nothing is without controversy, and in Arkansas they found a number of people were going through the eligibility process and when they got to the marketplace to select a plan, they would stop in their tracks. To solve that problem, they set up an auto-select protocol so if an eligible person does not select, and backs out of the enrollment process at the selection point, then the state automatically enrolls that person with an insurance company on a rotational formula. This is controversial, but it seems to be satisfying people. Complexity exists in the insurance marketplace.

Advantages of the Arkansas's Model are as follows:

- Doubles the size of the Arkansas marketplace enrollees, better leveraging economies of scale.
- Encourages private carrier entry.
- Expands service areas and access.
- Results in more competitive pricing.

- Increases access to medical providers who normally did not accept, or limited the number of Medicaid participants they served.
- Arkansas estimates traditional Medicaid expansion would have increased its Medicaid fee-for-service network by 40%, creating access problems.
- Reduces cost shifting due to uncompensated, indigent care. Increases payments to providers for existing uninsured patients they currently treat.
- Reduces churn between Medicaid coverage and health plans on the exchange.
- Requires health plans to participate in its payment improvement initiative, expanding the number of providers participating in the state's payment and delivery system reform.

In the first two months, there was very high acceptance by the public.

**Director Armstrong** said that Arkansas is a SHIP recipient about six months ahead of Idaho and has the implementation grant. People must have insurance first, and then work within the healthcare system second.

Arkansas listed their advantages as follows:

1. Improve patient access to medical providers.
2. Reduce churn from Medicaid to marketplace policies.
3. Improve quality of care by requiring insurers to participate in payment improvement initiative.
4. Reduce costs for everyone in the marketplace exchange by doubling enrollees.
5. Improve the quality of health plans offered in the marketplace.
6. Reduce expenses for uncompensated care and cost shifting.

**Representative Rusche** said that when Oregon had their waiver, there was a cap on plan cost increase per capita, asking if that was part of the Arkansas proposal. **Director Armstrong** said the Oregon waiver is a very different model based on overall population movement to managed care. Revenue neutrality in the Arkansas model has to do with overall costs to the state, and that includes indigent costs. He said this is a very complicated discussion and more study needs to be done. One could argue if you narrowly look at the premium cost, it may be viewed as a bit more expensive, so it has to reach out broader than premium cost against the PM/PM that may come through the Medicaid benefit.
**Representative Rusche** said that in Idaho the carriers, while being not-for-profit, still have a margin required, and he asked if that was similar construction to the premium cost. **Director Armstrong** answered that the rate is exactly the same rate that the carrier is deployed to the regular insurance market. The margin is the same margin, but an interesting question was raised which is what is the risk profile of the population that you're moving to the carrier. Arkansas has no vehicle for extra premium to come to the carrier because the uninsured population for adults may be sicker than a standard profile. If this was applied in Idaho, using a state-based exchange to modify the benefits slightly, that rate would reflect more accurately the risk presented by that subset of the adult population.

**Representative Luker** asked about the population between 100 and 138%. It was his understanding that folks over 100% are able to pull down the subsidy if they get a private policy through the exchange. Are those moneys factored in somehow, or is it an either/or situation, you either get Medicaid funds or can you combine that subsidy and take that as an advantage to the program. **Director Armstrong** said it was either/or; the ACA says that a person can either be eligible for Medicaid or can be eligible for a tax credit, but not both. For a person between 100 and 138%, then the decision is what to go into. In Arkansas that is easy, since a person can go through an expanded eligibility category (100% paid-for premium) or a person can go in under the tax credit. Anyone above 100% is going to have some

premium, however small it might be, possibly in the $50 range, with identical coverage. **Representative Luker** said that with the subsidy most of the population between 100 and 138% would not end up on Medicaid because it would be cheaper since more is paid down through the subsidy. **Director Armstrong** answered: "No, the reverse would be true. They would be coming through the expanded population Medicaid money because that is 100% and it doesn't have any cost sharing other than in the benefit design. It doesn't have a premium cost-sharing if you're in the expanded population between 100 and 138%. If you were buying through the ACA and the advanced tax credit, then it would be a premium for that choice." **Representative Luker** was trying to understand the premium under Medicaid for the patient who is 100% covered, but in terms of state cost, he was trying to sort out that factor. **Director Armstrong** explained that the general fund side of it, under this expanded population, starts out at 100% and steps down to eventually 10%, so the state would have no more than 10% of the cost. There is no general fund tied to the subsidy; that is coming federally, so on the subsidy side either money comes from the advanced tax credit and from the individual. Those two pieces go to the carrier and that is 100% of the premium. From a general fund cost standpoint, there would be more state cost on this expanded population eventually. **Representative Luker** asked how the current managed care program would integrate to this type of program where the insurance may not pay on that type of a basis. **Director Armstrong** replied that the SHIP program is multi-payer, so all carriers were involved as well as Medicaid. The evolution of the healthcare system needs to go ahead without regard to any of these other subsidies or benefit plans. The advance of a state-based system over a federal is that we could then quickly integrate those managed care programs into the QHP. You could have fee-for-service, managed care, or a variety of capitation payments and a variety of structures within the benefit design that sit in the qualified health plan arena and people would buy those products and services would be delivered. The delivery side we want to move forward together regardless.

**Co-chair Collins** said that if most people go with what is being called "the silver plan" with co-pays and deductibles involved, he asked if the state Medicaid would then step in to pay those co-pays and deductibles on a hybrid plan. **Director Armstrong** said that in Arkansas the Medicaid program is supplementing the private silver plan up to the limits of Medicaid, so Medicaid typically says that the maximum out-of-pocket is 5% of income. After the QHP, it's like a coordination of benefits and it's complicated. **Co-chair Cameron** thanked Director Armstrong for his presentation.

The next presenter was **Ms. Amy Dowd**, Executive Director, Your Health Idaho, and her PowerPoint presentation is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_dowd.pdf

**Ms. Dowd** updated the task force and began by stating that Idaho was right to set up a state-based exchange to serve the people of Idaho. Primarily as a state exchange, Idaho has the flexibility to respond to changes in the marketplace and continue to make decisions that benefit Idahoans. In the past eight months, Your Health Idaho has worked diligently to meet goals and right now is doing two key things:

- Preventing federal intervention in Idaho, and
- Providing a much needed resource to Idahoans who want health insurance by building a system that meets Idaho's needs and is right-sized to Idaho and reacting to challenges with the flexibility of a state-based exchange.

**Ms. Dowd** said that Your Health Idaho has had state-based success in the following ways:

- Met all regulatory requirements to keep Idaho in control and qualified as a state-based marketplace;

- Smallest staff and low grant funding compared with other state exchanges;
- Set up a board of 19 volunteers, established governance, and are fine tuning responsibilities and accountability standards;
- Identified a plan for setting up their own marketplace for sustainability in 2016;
- Established a website to act, for this first year, as a portal to the federal exchange;
- Created Idaho-based resources for consumers to make up for shortcomings of the federal website, including tools to estimate tax credits, find consumer assistance and compare plans;
- Built a network of over 500 agents and brokers and 300 in-person assisters to help Idahoans;
- Completed their first financial audit in accordance with the enacting legislation;
- Preparing their first report to the Legislature.

**Ms. Dowd** said that compared to federally managed states, agents and brokers have only limited roles. In Idaho the fee was set at 1.5% and will run a right-sized operation; in federally-managed states, fees are set at 3.5%. Residents of federally-managed states have no choice in the amount of the fee, how it is paid or where it goes. Idaho's marketplace is governed by a board of Idahoans; in federally-managed states, the states do not have authority to govern or control funding. In-person assisters, training and background checks are more vigorous than in federally-managed states. In federally-managed states, states do not have local control over in-person assisters (IPAs) and navigators; they are chosen and regulated by the federal government. With regard to in-person assisters, Idaho made security and trust their top priorities. Employees or volunteers are from trusted, established non-profit entities around Idaho, are trained and cleared through national background checks. Partners have existing security and privacy standards.

Updates that impact exchanges include:

- Enrollment date has been moved to December 23rd for coverage beginning on Jan. 1, 2014. Open enrollment will continue through March 31, 2014.
- The Governor called for plan continuation and Idaho's insurance carriers will determine whether or not they will offer to extend coverage of existing plans through 2014.
- SHOP enrollment will be available through agents and brokers or direct enrollment for 2014; the online process will not be available until 2015.
- The federal site appears to be functioning better, but Idaho is moving forward to have our own technology system in 2014.

**Ms. Dowd** said that all "live" functions of the Your Health Idaho website have passed security testing. Standards are the same as the Medicare system. All functions that are not "live" have not completed security testing. The Your Health Idaho consumer resource center has taken 6,500 calls (generally answered within 15 seconds), answered 500 emails, and 565 referrals were made to agents, brokers and IPAs. She said that the HealthCare.Gov call center has dealt with 12,000 calls from Idaho. The Your Health Idaho website has had 120,000 unique visitors and 618,452 page views.

**Ms. Dowd** reported that from October 1 through November 2, 2013, Your Health Idaho had 4,753 completed applications; 10,573 Idahoans were included in those completed applications; 7,733 Idahoans were eligible to buy a plan on the marketplace; 3,305 applicants were eligible for tax credit; 338 Idahoans have selected a plan. These numbers are encouraging and will grow; Your Health Idaho will build a system designed for sustainability by 2016. **Ms. Dowd** shared other state enrollment numbers to the task force for comparisons. Idaho's marketplace is lean and moving at a much faster pace, but numbers are in line with other states. Idaho has done in seven months what other states took

years to do, with much less money. **Ms. Dowd** showed vendors supporting Your Health Idaho to implement the state-based marketplace, using other people's expertise to get it up and running with the lowest staff number.

**Ms. Dowd** said that with regard to technology, Your Health Idaho is pleased with the quantity and quality of proposals received. Finalists have been identified. Due diligence is being exercised for Idaho to avoid issues the federal marketplace had going live. They will move into contracting as quickly as possible. This is the next big partnership for the marketplace, and they are taking the time to select the best solution partners to ensure the design is sustainable and the system will be thoroughly tested. The benefit of implementing Idaho's marketplace is that they have learned lessons from the federal marketplace as well as from other states. In summary, she said that Idaho has successfully met all requirements to keep our exchange controlled in Idaho. Idaho's marketplace is built for Idahoans, by Idahoans. We are moving forward to build an exchange that is sustainable by 2016.

**Representative Luker** read an article about security with regard to Healthcare.gov which stated that no security was built into the Obamacare website. His question was about assurances from the federal government and whether the exchange had done any independent review or audit of security for Healthcare.gov. **Ms. Dowd** said this is a very important issue and one they have been tracking closely. She said that concerns have escalated requests for additional information on security through our state office and leadership through CCIIO, CMS and HHS. Options have been explored for hiring an independent review and the challenge of that is that the initial response back from the federal government was that to do so would require using grant funding, and that has been denied. Security is being tracked very closely.

**Senator Vick** stated that in other states, the vast majority signing up are signing up for Medicaid and not insurance, and he asked for those numbers for Idaho. **Ms. Dowd** said she did not have the breakout between those two, but of the 338 who had selected a plan (October 1 – November 2, 2013) through the marketplace, she said those were not Medicaid applications. The Medicaid information will be made available to the task force.

**Senator Schmidt** asked about the completed number of applications, asking if these applicants were above 400% or below 100% (federal poverty level). **Ms. Dowd** said that she did not have that level of detail available at this time, but she will bring that back when it is available. **Co-chair Cameron** added that they could have been listed as not eligible because the applicant or spouse had employer-based coverage. **Senator Schmidt** asked about people eligible and the small number who did enroll; those from Arkansas received a "nudge," and he asked if Idahoans had a similar "nudge" in the enrollment procedure available. **Ms. Dowd** asked for clarification, wondering if he meant applications started and not completed, and he said that was correct, and why. **Ms. Dowd** replied that early market research shows there are individuals who begin the application process to understand plans, options and subsidies available, and then come back to make a decision at a later date, usually about two weeks. In the federal marketplace there is follow-up occurring with individuals who have initiated but not completed the process, so her answer was "yes." **Co-chair Cameron** commented that he didn't believe the early information available is indicative of what is really going on. Many people started completely over in the process.

**Representative Hixon** asked about window shopping on the exchange and if there were any updates on where that stands and what kind of reflection that has with regard to numbers in her presentation. **Ms. Dowd** answered that with the launch of the federal marketplace, there is also an updated anonymous

browsing site that Idaho has not included in our first version, but this will be included in the next version, within several weeks. They are checking to see if Idaho can be added to the federal browsing tool before anything is implemented. **Co-chair Cameron** thanked **Ms. Dowd** for her presentation.

The next presenters, **Austin Bordelon** (not Brett Graham, who was shown on the agenda) and **Dan Schuyler**, Leavitt Partners, participated via telephone conference call, and their PowerPoint presentation is available on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_leavitt.pdf
They had been asked to enter into a discussion of insurance exchanges in other states. They gave an update of the federal marketplace, a state exchange update, and stood for questions. **Senator Cameron** said that there was not a lot of good news, which made the Idaho exchange look like it's doing very well.

**Senator Vick** asked about the enrollment numbers beginning on October 1st and he asked about an ending date for the numbers presented. **Mr. Bordelon** replied that in every state, that ending date could be different, but he had given the most recent releases of enrollment information, adding that this had been surprisingly uncoordinated. With regard to the state of Washington, the end date was November 14th, 2013; for New York, the most recent release was December 2nd, 2013. Every state-based exchange is releasing information at varied intervals, with the exception of Hawaii and Massachusetts, who are not yet releasing data. Different state exchanges track data at different levels of detail also.

**Senator Tippetts** said that when an Idahoan logs onto the exchange, eventually that person gets transferred to the federal exchange until the state exchange is fully functional, asking if Idaho was unique in that regard. **Mr. Bordelon** said that other states have taken this approach, such as Arkansas. It makes sense to direct consumers to Your Health Idaho initially, recognizing that the underlying technology is provided by the federal government, and why consumers are transferred to the Healthcare.gov website. As Idaho's capabilities get built out, he said that more technology will reside on the Your Health Idaho website. **Mr. Schuyler** added that doing it the way Idaho is doing it presently helps to establish the Your Health Idaho brand with respect to consumers. Once Idaho transitions to a state-based exchange, that brand will be established in the mindset of consumers, believing this is the best way to do this.

**Co-chair Cameron** asked about states that have gone to the federal exchange and are being charged a 3.5% administrative fee per premium; Idaho is at 1.5%, and he asked about fees in other states. **Mr. Bordelon** replied that every state has taken a different approach for revenue generation for sustainability of their exchanges. Most states have taken a broad approach, such as California where it starts out as a 2% premium tax for all insurance carriers in the state and as years go by that gets ratcheted down to 1%. In contrast, Nevada is collecting a per- member, per- month fee he thought was around $5, plus change. States like Maryland require participation for all insurance carriers who offer products in the individual market. If they make more than $10 million in premium revenue, they are forced to participate on the insurance exchange and the exchange is financed by an existing tax, somewhere around 2%. Every state-based exchange has taken a different approach. **Co-chair Cameron** thanked them for their presentation.

**Co-chair Cameron** recessed the task force for lunch at 11:45 a.m. until 1:30 p.m.

The task force reconvened at 1:34 p.m. and the next presenter was **Ms. Elke Shaw-Tulloch**, Administrator, Division of Public Health, DHW, who gave an overview of the Time Sensitive Emergency (TSE) System of Care. Her PowerPoint presentation is on LSO's website at: http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_shawtulloch.pdf
**Ms. Shaw-Tulloch** informed the task force that Idaho is one of only a few states who do not have a comprehensive system of care for time-sensitive emergencies which include trauma, heart attack and strokes. There is a statewide trauma registry and coalitions that were formed and are ongoing, but what was lacking was the ability for hospital designation and certification. In the past several years, the Health Quality Planning Commission has looked at different systems of care and looked to Montana as a model trauma system, to include strokes and heart attacks as part of the structure. Last year HCR 10 was passed that created the Time Sensitive Emergencies System of Care. This directed DHW to convene a workgroup to develop elements of system structure, funding mechanisms, an implementation plan, and to bring forth enabling legislation around trauma, strokes and heart attacks.

**Ms. Shaw-Tulloch** said there was an incredible work group of 40 participants who worked from May to November, 2013, and they met monthly to meet goals. The work, to date, included working on products to bring them forward to gain consensus. Other states were researched, and draft legislation is in progress. There is a mailbox for questions and input about the program, presentations are being made, and a final report is being written. The basis of work is looking at a continuum of evidence-based care starting with the instant people call 911, taking that person to the hospital, taking that patient to the right place at the right time, through the hospital system and back to acute medical care and to rehabilitation. The quality improvement piece is to make sure that the system created is continually being improved and based on evidence-based care.

**Mr. Wayne Denny**, Bureau Chief of Emergency Medical Services and Preparedness, Division of Public Health, DHW, addressed the task force about the proposed system, the structure, and the next step.
**Mr. Denny** said that under DHW there would be a state board to address trauma, stroke and heart attack, with work being done in regions through time-sensitive emergency committees, six that would exist within Idaho in different areas. EMS hospitals and public health rehab community members make those regional TSE committees work. That state board will have 18 members appointed by the governor and the board will establish standards. They based the resource facility locations around hub hospitals. There will be regional representation back to the board, educational opportunities especially for rural EMTs, quality improvement, coordination in the region, and technical assistance.

**Mr. Denny** said that with regard to designation of certification, wherever possible, national standards and best practices will be used where they fit. Five levels of designation are necessary, to include hospitals who may not be able to rise up to a level four. Any hospital that is a participant of this system could use a billing code that can bill for trauma activation. This would be a funding mechanism for those hospitals that choose to participate. Legislation is being drafted that establishes the TSE system and adds stroke and heart attack data collection into the existing trauma registry. Rules would be developed in year 1 and year 2 to define the components or guidelines for trauma, stroke and heart attack and to detail levels of the system. Trauma rules will go to 2015 legislature; stroke and heart attack rules will go to 2016 legislature.

**Senator Tippetts** asked what a Time Sensitive Emergency System for Care was, asking if it was about certification for hospitals to treat trauma, heart attack and stroke so that when an emergency occurs, the individuals, based on geographical location, will be taken to certain facilities, asking what more can be explained about the purpose behind this system. **Mr. Denny** said this system creates a venue and the

certification. It establishes a place where all the EMTs, the rehab, the hospital folks can get together to discuss these three issues before things happen so that when am EMT rolls up to a home, they know where to take that patient. The closest hospital may not be the best place. Protocols need to be figured out ahead of time, so this system would address that. Many areas do this type of work, but it is not in a structured, organized fashion, as it should be. **Senator Tippetts** asked if participation by all the various entities is completely voluntary and **Mr. Denny** affirmed that it is voluntary. He said he couldn't imagine any hospital not wanting to participate. If hospitals are hesitant, he thinks they will want to get involved, once they see the system working.

**Representative Luker** asked about the process of certification. What would the consequence be if standards were not met or if there was a lapse, since this system plan is voluntary? **Mr. Denny** said that a lesson learned from Utah and Montana was on this issue, and if this occurs they would work with that entity to get them back up to standards or moving toward a goal, rather than decertifying or taking them out of the system, yet balance that with keeping the system safe. Level five gives trauma hospitals the ability to participate at the highest level they can and most hospitals can participate in level five, without adding to their costs, just by adding in procedures and protocols. Many hospitals could then move up to level four.

**Representative Rusche** clarified that time-sensitive emergencies were those conditions for which a delay in definitive treatment makes a significant difference in the mortality or morbidity of the condition. The Health Quality Planning Commission (HQPC) realized that Idaho has an excess cost in many places in Idaho because there is no organized system, which is what led the HQPC to have a system plan developed. Community awareness and prevention is also important and part of this system, as well as making sure there are first responders. Some places in Idaho have a difficult time getting volunteer first responders, and a system can help deliver training to individuals or organizations that need it. He thinks that rural parts of the state will benefit especially from this system.

**Representative Hixon** asked about this system being a revenue generator for hospitals, asking where the increase would come from and what kind of percentages might be expected from a regular hospital that deals with these traumas. **Mr. Denny** answered that a "68 billing code" is something that payers will only take a bill for that code if it's from a trauma center. Amounts of funding would be substantial enough to fund a trauma system within a hospital. **Representative Hixon** asked what kind of impact this would have on the general Idahoan, wondering about a patient receiving a huge bill and not being able to pay the provider with this new billing code. **Mr. Denny** said that only that billing code is about generating revenue and it allows hospitals to offset costs to them. He said that he was most concerned about the cost of human life, rather than the dollars and cents of this system, going all the way down to the EMS level. Billing practices of the hospital are up to individual hospitals, and would not be driven by this system. **Co-chair Cameron** thanked them for their presentation.

The next presenter was **Dr. Kendra Witt-Doyle**, Foundation Manager, Blue Cross of Idaho Foundation for Health and her PowerPoint presentation is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_wittdoyle.pdf
**Dr. Witt-Doyle** gave an overview of the High Five Program to Fight Childhood Obesity. She said that obesity has reached epidemic proportions causing serious health problems that are "crippling" the U.S. and resulting in $190 billion annually in healthcare expenditures related to obesity. Twenty-seven percent of 18 to 24 year-olds are too overweight or obese to enlist in the military. This generation of children is projected to have shorter life expectancies than their parents. **Dr. Witt-Doyle** shared trends from 1985 through 2011 assessing obesity showing what an epidemic this has become in the U.S. In

Idaho, in 1985, less than 10% of adults were obese and by 2011, 30% of adults were obese. If this trend continues, by 2030, 42% of American adults will be obese. One in 3 children in Idaho is overweight or obese. Healthy behaviors need to be taught at a young age, and this is why this collaborative was started. It is a statewide effort to fight childhood obesity in Idaho. Five proven strategies include improved access to healthy and affordable foods; increased physical activity; healthier schools and childcare facilities; education to help parents make healthier choices; and promotion of public policies that fight the causes of obesity.

**Dr. Witt-Doyle** said that it will take a village. Childhood obesity is a complex issue that needs individuals from multiple sectors working together, and she said that High Five is not about Blue Cross of Idaho, but High Five is being powered by them to provide a platform for this statewide effort. The High Five Program awarded grants to cities. Thirty-four applied and four cities were awarded. These communities will work with the High Five Program over the next 3 years to make sustainable community changes. High Five is sending out "daily do" texts or emails to parents to provide a tip such as a healthy recipe or nutrition tip. Media outreach and partnerships with High Five support fighting childhood obesity. Learn more about High Five at HighFiveIdaho.org.

**Representative Luker** asked where funding came from for High Five grants. **Dr. Witt-Doyle** said that right now funding is coming from the Blue Cross of Idaho Foundation.

**Representative Hixon** asked if low-income areas and socioeconomics contribute to obesity and **Dr. Witt-Doyle** said that low income and obesity are related and that current research shows that a zip code affects health more than one's genetic code. She agreed to send the members more information and research on this. **Representative Hixon** wondered about her comment about "tracking cell phones" and **Dr. Witt-Doyle** explained that information was collected by a telephonic survey.

**Senator Lodge** asked about working with Food Stamp recipients to encourage purchase of healthy foods. **Dr. Witt-Doyle** said this was something that will be discussed in partnership building, but the discussion had not taken place yet. She agreed that nutrition education is very important, as well as how to best shop on a budget. **Senator Lodge** asked about cities receiving grants and if there was certain criteria for them to follow in order to receive the grant, and will progress be monitored. **Dr. Witt-Doyle** answered that when cities applied, two things had to be demonstrated: (1) they must be motivated to take steps to address childhood obesity, and (2) that community had a need. High Five will conduct a needs assessment within communities, a three-year action plan will be implemented and measurement will be built in, although difficult, since this pertains to children.

**Senator Goedde** acknowledged that childhood obesity is an important issue, and he thanked **Dr. Witt-Doyle** and the foundation for their work. He asked how often, over the years, has the definition of "obesity" changed. **Dr. Witt-Doyle** replied that she didn't think that definition of body mass index (BMI) had changed over the years, but offered to research that for **Senator Goedde. Co-chair Cameron** thanked **Dr. Witt-Doyle** and the foundation for their work.

**Co-chair Cameron** informed the task force that the next three agenda items were presenters of draft legislation and he reminded the new members of the task force as to the role of this task force. He said this task force was formed first and foremost to look at ways to reduce healthcare costs and it expanded into a group with a level of expertise to look into more in-depth issues to make recommendations. The co-chairs agreed to allow these three pieces of legislation to be presented at this meeting. He clarified that this did not mean the co-chairs were for or against the drafts. He said that motions on these drafts,

or no motion at all, would be considered appropriate by the members. Healthcare legislation is not required to be brought before this task force, but he said that the parties do hope the task force would endorse or give them suggestions. A vote on this task force would not obligate members to vote on a draft down the road in a formal setting. This task force does not take the place of germane committees. The members are seeing draft legislation without a fiscal impact statement, and comments from the public have not been heard at this venue, which could make it difficult for members at this task force to make a decision. If members have an issue or concerns, those can be voiced so that the proponents of these drafts can take those into consideration. **Co-chair Collins** agreed that one option of the task force is to do nothing, and he emphasized that the members of this task force were under no pressure to make a decision on these three pieces of draft legislation. **Co-chair Cameron** said if this task force takes no action on a draft, this does not preclude the sponsor of the draft from going directly to a germane committee. He did encourage people with significant healthcare legislation to bring it to this task force because of the caliber of expertise available. He asked if there were any questions by the members, and there were none.

The Treasure Valley Food Allergy Network brought the first Draft RCB045 by **Starla Higdon**, Executive Director. The legislation was regarding increasing access to epinephrine auto-injector pens in schools and her PowerPoint presentation is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_higdon.pdf
The draft legislation is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_higdon2.pdf

**Ms. Higdon** introduced Dr. Nathan Andrew, Alicia Jordan (nurse) and Vivian Meisenbacher (lobbyist for Mylan Specialties that markets the epi-pen) who were available to answer any questions. **Ms. Higdon**, a pharmacist, explained that anaphylaxis is a severe, potentially life-threatening allergic reaction. Many substances can trigger anaphylaxis, including but not limited to foods, insect stings and latex. Epinephrine is the first-line treatment for anaphylaxis. Anaphylaxis can occur without warning, even in people without previously diagnosed allergies. Anaphylaxis can progress extremely rapidly, sometimes within minutes. Epinephrine must be administered as soon as possible to be most effective.

**Ms. Higdon** said that the incidence of food allergies is rising, especially in the pediatric population and currently affects 1 in 13 children, roughly two in every classroom. Studies indicate that close to 25% of epinephrine administrations on school grounds were to students or staff that had not been previously identified as being at risk for anaphylaxis, and did not have medicine on hand prescribed for them. **Ms. Higdon** said that the draft legislation proposes that schools have a supply of epinephrine on hand that is not specific to any one child. Student fatalities in Virginia and Illinois highlight the need for improved access to epinephrine in schools.

**Ms. Higdon** said that the proposed legislation would allow schools to obtain undesignated epinephrine auto-injectors (and would allow participation in free or discount programs offered by manufacturers). It would authorize school nurses and designated, trained non-medical personnel to administer an epinephrine auto-injector in an emergency. It would grant Good Samaritan protection to school systems, prescribers, school nurses, and trained personnel when acting in good faith in an emergency. It would require the State Board of Education (with DHW) to develop guidelines for the management of students with life-threatening allergies.

**Ms. Higdon** said there are currently four types of epinephrine auto-injectors available. If properly stored, the shelf life of an auto-injector is generally between 12 and 18 months at time of dispensing. The EpiPen4Schools program provides free and discounted auto-injectors to schools.

**Ms. Higdon** said this proposed legislation has support from a number of stakeholders. She said that the Federal School Access to Emergency Epinephrine Act was recently passed and rewards states that have legislation to manage life threatening allergies in schools. It authorized the U.S. Department of Health and Human Services to give funding preferences to states for asthma-treatment grants if they require their schools to: maintain an emergency supply of epinephrine; permit trained personnel of the school to administer epinephrine; and have a plan in place for ensuring trained personnel are available to administer epinephrine throughout the entire school day.

**Senator Goedde** asked about the four free epi-pens per school; he asked if that was per school district or per school building and **Ms. Higdon** said it was per school.

**Representative Luker** asked about risks of epinephrine and why is it so tightly controlled. **Dr. Nathan Andrew** answered that epinephrine is tightly controlled because it is an injection but also because it has a potent affect on the heart and vascular system. It is used extensively in emergency medicine. If it is used and not necessarily indicated, meaning that if someone mistakes an allergic reaction, it has a very short 10-15 minute half-life and metabolizes very quickly, so there are virtually no conditions for which it is contra-indicated. It would be very unusual in which it could be harmful to someone, unless that person had a rare cardiac disease, such as in the elderly population. **Representative Luker** asked if there were objections from schools being required to have epi-pens on site. **Ms. Higdon** said they had not received full opposition, but there are questions and the mandate was requested to be removed requiring schools to stock epinephrine, wanting it to be optional. **Representative Luker** asked what an undue burden would be for a school. **Ms. Higdon** said the fiscal impact has been a concern, but she said the EpiPen4Schools program provides four free auto-injectors per school , per year. The only cost remaining would be for training of the designated personnel.

**Representative Hixon** asked about the draft legislation and the wording ". . . there shall be no civil liability for damages for a school or its employees or agents for any injuries that result . . ." and also ". . . regardless of whether authorization for use was given or not by the student's parents, guardian or medical provider . . ." and he expressed concern. **Ms. Higdon** answered that anaphylaxis can be a rapidly progressive condition, and there is often not time to get permission prior to giving an injection. Other states that implemented this law incorporated paperwork for parents to sign giving permission, if this were to happen. The liability (Good Samaritan) clause is in this draft to protect the school systems and designated personnel from any sort of liability when acting in good faith. **Representative Hixon** asked if there was a big risk factor in giving an injection to a child not having anaphylaxis. **Ms. Higdon** said that there are two different dose amounts for different sizes of students. Epinephrine is very safe and is basically the same substance that our body emits in fight-or-flight responses when adrenaline kicks in. The effect of the injection is also very short-lived.

**Senator Vick** wondered how many cases there were in Idaho last year where epinephrine would have been used. **Ms. Higdon** said this is not tracked in Idaho. **Co-chair Cameron** asked for **Ms. Jordan** to comment, as a nurse, how big of a problem this is and why schools, on their own, don't supply epinephrine. **Ms. Jordan** responded that there are many children who have allergies who carry their personal auto-injectors prescribed by a physician. Schools have to have a doctor's order to have

epinephrine for students. Also, not all schools have a school nurse or a doctor over a school district to give those standing orders.

**Representative Rusche** responded about children who are less susceptible to adverse effects of epinephrine. He said that the primary effect is an excess contraction of the heart muscle (angina) and arteries in children are almost always open, so they are much less likely to have problems.

**Senator Schmidt** asked if the Board of Pharmacy or the Board of Medicine had been consulted with regard to statutory prescribing concerns. **Ms. Higdon** said the Board of Pharmacy had been consulted and they did identify some wording that needed to be changed if this draft went into effect. The Board of Medicine had not been consulted.

**Co-chair Cameron** asked if a fiscal impact had been determined for this draft legislation. **Ms. Higdon** answered that the EpiPen4Schools program would take care of the medication cost for the vast majority of schools, but training costs were not known. Maryland found that cost to be minimal when they implemented similar legislation. **Ms. Higdon** offered to get that information for the members. **Co-chair Cameron** thanked Ms. Higdon and those who came with her for their presentation. He asked if there was further discussion or a motion with regard to this Draft RCB045, and there was not.

The next presenter was **Mr. Ken McClure**, Idaho Medical Association (IMA), and his handout is available on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_mcclure.pdf
**Mr. McClure** said that his handout covered IMA priority items that will be addressed in 2014 as follows:

1. Medicaid Redesign
2. Medical Education and Residency Program Funding
3. Violence Against Health Care Workers
4. Idaho Community Standard of Care Protection Act
5. Time Sensitive Emergencies System of Care
6. Change to Idaho's Prescription Drug Monitoring Program
7. Scope of Practice and Provider Licensure Legislation
8. Updating Idaho's HIV Transmission Statute
9. Healthier Options for Idaho Food Stamp Program Participants

One piece of draft legislation addressing violence against health care workers is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_mcclure2.pdf

**Mr. McClure** said that last year draft legislation on violence against health care workers passed the House; in the Senate there was a tie vote, and after the Lt. Governor's vote of "no," this bill did not pass. This year, in response to debate, the draft was redone and the IMA hopes that the Senate will pass this in 2014. There is a real problem with violence in healthcare; current laws are not working, and violence is becoming more prevalent nationwide. A proposed solution has been drafted, and he introduced his daughter, **Emily McClure**, to explain the issue.

**Ms. McClure** said that there are enhanced penalties under Idaho law for committing battery and assault against certain classes of professionals. For example, it is a felony to assault or batter an EMT, police officer, or an employee of the Tax Commission. There is a serious problem with violence against healthcare workers, particularly in emergency rooms and especially by those seeking drugs. Healthcare professionals are unique in that they are required to treat people whether violent or not, and they must

be in close physical proximity to patients. This draft legislation would make it a felony to batter a healthcare worker or employee. The risk of job-related violence against healthcare and social workers is presently higher than for any other field. Nationally, between 2002 and 2010, 69,500 nurses and 10,000 physicians were assaulted and battered. From 1993 to 1999, incidents of violent crimes against healthcare workers were two times higher than that of any private-sector occupation. A recent survey shows that the likelihood of a healthcare worker being the victim of a violent crime in the workplace has grown to three times that of any other private-sector occupation. Approximately 50% of all non-fatal injuries to workers from violent acts occur in a healthcare setting. One in four emergency room nurses reported being assaulted or battered more than 20 times over the past 3 years. Violence increases as the number of drug and alcohol-related patients rise. Seventy-three percent of healthcare workers reported being afraid of patients; 49% hide their identity from patients; 25% took days off work due to violence; 48% reported that job performance was impaired for a shift or longer after an incident of violence. Ninety percent of emergency department managers have cited patient violence as the greatest threat to emergency department personnel. Healthcare workers have the highest incidence of days away from work resulting from injury.

**Ms. McClure** stated that the bill introduced last year aimed at trying to curtail this problem, and they began by adding healthcare professionals to the long list of professionals protected under Idaho Code 18-915. Concerns by legislative members were addressed and the potential of 25 years in prison for a conviction was shortened to a potential maximum of five years. The bill was changed to include a qualifier that a victim must be assaulted or battered because of that person's profession or during the course of performing that profession. To cover assurances that the mentally ill would not be swept into this bill, a clause was added saying that mental illness was an affirmative defense. Criticisms heard in debate in the Senate resulted in a redraft of this legislation which responds to that criticism and she said they hope it will now be better received. This draft differs from last year's bill in that the application to assault was dropped and the new draft is only applicable to battery, which is the physical touch. There is a qualifier that battery must take place when the victim is performing professional duties or because of the victim's employment status. Finally, it also includes the sentence (not to exceed five years). **Ms. McClure** stood for questions.

**Senator Schmidt** asked what "an affirmative defense" means legally and **Ms. McClure** said that if someone has been charged with battering a nurse and that person gives an excuse such as: "I am schizophrenic and I was in the midst of a psychotic episode," that is an affirmative defense. **Senator Schmidt** asked **i**f schizophrenia was an affirmative defense, and would acute withdrawal from narcotics also be an affirmative defense? **Ms. McClure** said cases would have to be weighed individually according to circumstances, but the section of law stating that intoxication is not an affirmative defense does apply.

**Representative Rusche** asked how to define mental illness and what is substance abuse since there is such consistent overlay of the two. **Ms. McClure** read the following: "It shall be an affirmative defense to a violation of this statute that the action was taken by a person who because of mental illness or disability or because he is under the influence of lawfully obtained and properly used prescription drugs lacks the ability to form the intent to commit the crime." **Representative Rusche** asked about evidence showing that enhanced penalties lessen the committing of a crime. He assumed that few people, even if seeking drugs, go into a healthcare facility with the intent to batter someone, so he questioned whether the enhanced penalty and longer prison time would affect the incidence of battery. **Ms. McClure** said that the goal was not to imprison multitudes of people but rather a deterrent effect to prevent these violent acts from happening. She talked about an emergency room doctor in Arizona who worked

before a similar law was passed and after, and that doctor reported that he experienced a marked decrease in violence after the passing of legislation. Another side effect of this legislation is that police respond to felonies and they can't always respond to misdemeanors. Hopefully this will engage police in these acts of violence and to encourage healthcare workers to report such acts, since acts are highly under-reported currently. **Representative Rusche** said it sounded like this legislation would be a component of a multi-faceted strategy including training of law enforcement, perhaps restructuring emergency departments being set up for greater protection; he said that he looks forward to how this all comes together.

**Senator Lodge** agreed that this was a problem, but added that she had spent the last eight months studying the criminal justice system and she expressed concern about long sentences and wondered if some jail time, treatment, education of civility would help some of these offenders. She wondered if there was more security in emergency rooms if there would be less violence. She asked if a misdemeanor would mean jail time and **Ms. McClure** said it could be jail time or a fine. A felony is only a felony if you don't offer the court an option of imposing a fine. **Senator Lodge** would prefer looking at this another way, rather than creating another law, although realizing that safety is a serious issue for healthcare workers. She would hope that offenders could receive treatment that they would pay for, rather than prison time. **Ms. McClure** said there probably needs to be a multi-faceted approach to this issue. This legislation could be helpful particularly in instances of "frequent flyers" who come into emergency rooms repeatedly with drug-seeking behaviors and knowing there is no consequence for their actions. If there is a greater consequence and police involvement, then a repeat offender is less likely to reoffend.

**Senator Tippetts** said he certainly was supportive of protecting healthcare workers but he struggles with the rationale of this and similar legislation because if current penalties are not sufficient to provide the appropriate level of deterrence for the crime, then it seems to him the penalty should be increased, regardless of who the crime is perpetrated on. Why provide enhanced levels of protection to some elements of society and not to others. If penalties are inadequate as a deterrent, why not increase penalties? **Ms. McClure** commented that under federal law, healthcare workers are required to treat patients regardless of whether violent or not, and they are in close physical proximity to perform those duties, and healthcare employees and providers are at markedly greater risk than those in other sectors of society. **Co-chair Cameron** thanked Mr. McClure and Ms. McClure for their presentations, and the task force had no comment or motion on the draft legislation.

The next presenter was **Mr. Tom Donovan**, Deputy Director, Department of Insurance (DOI), and his draft legislation (RS22420) regarding Risk Based Capital (RBC) in on LSO's website at: http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1209_donovan.pdf

**Mr. Donovan** said this draft was to amend existing law, Chapter 54, Title 41, and he said this deals with financial reporting to the Director of DOI. To become an insurance company licensed with a certificate of authority in Idaho, a company generally must have $2 million of capital or surplus. Many years ago, insurance regulators across the country realized that those minimum levels of capital were not sufficient given various business models and the nature of risk that insurance companies had. Collectively, a system was brought forth to require a minimum capital adequacy standard that is related to the risk insurance companies have. Idaho enacted its RBC law in 1996 and has two main components. Every year when an insurance company files a financial report with DOI, it files an essential RBC report and puts its information into an RBC formula. That formula is one component of the RBC system and the second is the law that sets forth the different levels that either pass muster or have different graduated

levels where the Director can take certain regulatory action against a company. The proposed legislation has two primary goals, both driven by accreditation standards which are minimum standards that the NAIC sets forth for insurance departments throughout the country to maintain an accredited status. This promotes efficiency among states and it reduces cost of compliance with regulation for insurance companies and promotes reciprocity. When an insurance department is accredited, if a company is domiciled in that state and goes to do business in another state where it is licensed, that other state would rely on the accredited state's regulation. The first thing that the proposed legislation would do is expand the scope of RBC to include health organizations. The second primary motivator for this legislation is that it accelerates the trigger for a company's action level event from 2.5 to 3.0. This involves life insurance companies that have had a negative trend and their capital level is at least 200% or two times the amount that would trigger a company action level on its own. But if a company has had a negative trend over time and is set forth in the formula, they would trigger it if they had 300% of their capital level or three times the amount which is the case for P&C companies. The other thing this legislation does, consistent with model language, is that it is expanded to include fraternal benefit societies and their filings would closely match that for life insurance companies. It also clarifies the confidential nature and treatment of RBC reports and plans which companies must file if their RBC level has fallen to a certain level to provide information to DOI to explain how they plan to get that RBC level raised. Those are the main things that this proposed legislation covers, and **Mr. Donovan** stood for questions.

**Representative Rusche** asked if this legislation would apply to risk-bearing provider organizations and **Mr. Donovan** said he was not sure of the definition of that term. If that included managed care organizations, they are already subject to it, and DOI looks at an entity on the facts to determine whether it needs to comply with licensure requirements under existing law, so that situation would have to be looked at. **Representative Rusche** gave examples of a provider who delivers a service and says no matter how much it costs, we will write off everything the insurance doesn't cover, so they bear the financial risk for that service. The other might be an integrated professional organization, hospital, physician, etc. who does a percent premium deal with a carrier. They are bearing 85% of the risk and he asked if they have any requirement for RBC under this or only the one who has the insurance licenses. **Mr. Donovan** replied that it would be only the entity having the license, but he had seen instances where folks have come to DOI and said there is a business model and wondering if it would require a license. Sometimes DOI says "yes" and sometimes it says "no." The basic definition of insurance is a contract where someone undertakes to pay a benefit based on determinable risk contingency. So, if there is a written contract where they say they are going to do that, and that is the main element of the contract, then maybe when talking about providers who enter into contracts with carriers to not charge full amounts, then it probably is not in that sphere. He said that DOI looks at things when people come to DOI based on facts as covered in the contract. In the two examples given by **Representative Rusche**, he said, he didn't think they would have to file. **Representative Rusche** asked about a carrier who layed off risk to a provider organization; if they did that to a reinsurer, the reinsurer would have to be filed with DOI, correct? **Mr. Donovan** answered that reinsurance is insurance by another insurance company; he thought that depending on the reinsurer, they may or may not be filing an annual statement with an RCB report connected to it. If they are, then they would file.

**Senator Schmidt** asked about the definition of a "fraternal benefit society." **Mr. Donovan** said the definition is in Chapter 32 and is basically a collective organization that comes together to insure or provide insurance for members; they have to operate on a lodge system, an example being Knights of Columbus. They provide life insurance or annuities to members. **Senator Schmidt** asked if that definition needs to be in this legislation and **Mr. Donovan** said that since there is a separate chapter that

provides that in Title 41 under Section 7 at the bottom of page 8 and top of page 9, that is where the definition shows up, so he didn't think that a reader would be confused and would know where to go.

**Representative Luker** asked if this would change the relationship at all between DOI and those fraternal benefit societies; is this reorganizing only, or is something changing substantively in that relationship? **Mr. Donovan** replied that they will have to file RCB reports with DOI although he implied but didn't state expressly that with accreditation and domestic companies, the RCB reports are really only filed with a domestic regulator and the NAIC and not filed necessarily with every state. Idaho has a section in law currently that gives authority to ask for a foreign company to file an RCB report with DOI. Idaho currently has no domestic fraternal benefit societies that are licensed; some are licensed but domesticated in other states. Practically speaking, it would not change. Legally, if there was a domestic one, they would have to file and DOI has the authority to ask for foreign ones. **Representative Luker** used an example of the "Woodsmen," a foreign fraternal society. He thought that it wouldn't change your DOI relationship with them, but if a group in Idaho wanted to create a similar organization, would they be subject to this change? **Mr. Donovan** said that was a fair statement, and would be subject to this filing.

**Co-chair Cameron** asked if the "Woodsmen" don't subsequently change, if someone filed a complaint or there is concern about how a company is operating, DOI could request it now under this change in the law, where in the past they could say that DOI did not have the authority to request that. He asked if this was accurate. **Mr. Donovan** said this legislation makes it a little more clear; however, DOI takes the view that they have the authority to request it from a general authority statute to ask for information about people who are engaged in the business of insurance and licensees. If that didn't work, DOI could get it from the domestic regulator realistically, but the Director of DOI has broad authority to request items from members engaged in the insurance industry or licensees, so he said he would not concede that point that DOI doesn't have the authority currently, but he said that it makes it more clear. **Co-chair Cameron** thanked **Mr. Donovan** for his presentation and there was no discussion or motion on this draft legislation.

The next presenter was **Bill Deal**, Director, Department of Insurance, and he had been asked to discuss the President's decision to allow reinstatement of plans canceled under the ACA. The law dictates that starting January 1, 2014, current health insurance policies would be transitioned to what he called quality health plans that are part of ACA. Policies that were going to transition into new plans had to do with new rating rules, guaranteed availability and renewability of coverage, the pre-existing health status condition, and essential health benefits. That was the premise that DOI worked on as they moved toward January, 2014. Back in March, 2013, DOI got together with insurance companies and issued a bulletin outlining how Idaho should make that transition. He read part of this bulletin as follows: "Carriers shall discontinue offering all current non-grandfathered plans to new issuants after December 31, 2013, and to current insurants upon the first renewal after December 31, 2013. Of course, the discontinuation must be executed in compliance with Idaho Code 41-4707 and 41-5207." What that basically meant was that Idaho was going to be a little different than some insurance states and insurance commissioners who decided that the right thing to do was cancel all policies and make that transition on the first day of January, 2014; that is when the outcry came forth across the nation. In a more orderly manner, those policies would be terminated and transition would take place. In the two statutes referenced, it tells insurance companies they have to give 90 day's notice to their policyholders if a cancellation is going to take place. Those letters started going out in October for the January renewals, so some letters of non-renewal did go out. Companies knew what they were going to do to, moving forward. Then on November 14, 2013, President Obama decided that he would extend

enrollment out through 2014, even allowing current policies to stay in place into 2015. DOI received a memo from the Center for Consumer Information and Insurance Oversight (CCIIO) that said: "In light of the circumstances of the extension, under the following transitional policy health insurance, insurers may choose to continue coverage that would otherwise be terminated or canceled and affected individuals and small businesses may choose to re-enroll in such coverage under this transitional policy health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014, and October 1, 2015, will not be considered out of compliance with the market reform specified below under the conditions." So, the extension at that point would be taking place and people could keep their current policies, which was part of the promise for an additional year. When that came forth, DOI met with insurance companies to determine how to move forward. On December 3, 2013, Governor Otter issued a news release asking Idaho insurance carriers to consider reinstating coverage for individuals and small businesses whose policies were terminated as a result of Obamacare requirements that took effect on January 1, 2014. He further said that the carriers would not be told how to run their business. However, he proposed and the state enacted a state-based healthcare insurance exchange law that was designed to maximize flexibility for consumers and carriers under Obamacare. The Governor asked carriers if they could consider reinstating policies, but the Governor said he would not add another layer of restriction on the marketplace. **Director Deal** said that brings us up to date.

**Director Deal** said that DOI had been working with the four insurance companies in the marketplace and these carriers participating in Your Health Idaho have been very involved with DOI and have been working together formulating a plan that will meet the Governor's suggestion to reinstate those policies. He said that DOI was drafting a new bulletin that will have to do with the non-grandfathered plans and there is a new class of businesses called grandmother plans, another new term. **Director Deal** said this is a tremendous challenge to the insurance carriers because they have been changing computer systems and software as to what they thought was going to occur on January 1, 2014, so now running another software program if they extend policies and sending out notices to undo cancellation letters that had gone out is another issue. Carriers are under great pressure to accomplish a lot in a very short period of time. DOI wants everyone to know they have that opportunity to continue their current policies for another year into 2015 and they can still obtain coverage through the marketplace, as planned in the beginning. The third option is to not go through the marketplace but to buy insurance outside the marketplace which is a way that health insurance agents are working with customers, particularly ones that do not have an opportunity for a subsidy and with glitches in the federal website. DOI will meet with carriers again this week, he said, to discuss options and DOI will work with CCIIO because there are notices they have submitted that DOI wants to change a bit as to how to notify Idaho citizens of the opportunity to keep their policies, if that is what they want to do. DOI is moving forward trying to comply with the Governor's suggestion and make Idaho's marketplace work, and he stood for questions.

**Co-chair Cameron** said this was a difficult and complicated issue and he asked if the discussion on the effect on rates was brought up. He said that all carriers had to produce a rate for 2014 based on an expectation of who was coming into the marketplace and who that carrier might enroll. There is no question that they will still enroll those who are older and those who have health conditions. For those who are on higher deductible plans or less-qualified plans or people who are young and healthy who may choose to stay on an existing plan, that adversely affects assumptions that went into developing those rates. Was there any discussion on what that would do to rates and whether carriers would be given other opportunities to make adjustments based on this decision?

**Director Deal** said that DOI had spent considerable time with insurance companies discussing the rate change issues and the insurance companies at this point are going back to the drawing board because if coverage is extended out into 2015, the normal process results in rate increases over the years for medical trends. DOI asked insurance companies to take a close look at what those rates may look like because DOI doesn't want Idaho to be a state with a gigantic increase. Companies will work hard to be as consistent as they can with rate increases going forward. He said this is a very big issue.

**Representative Rusche** asked if the continuation would be for in-force policies and no new policies with the old benefit structures including exclusions for pre-existing conditions and other benefit exclusions. **Director Deal** said that in order to be a grandmother policy, the policy had to be in effect before October 1, 2013, and those policies are the ones that can be extended into 2014 and possibly 2015. **Representative Rusche** said since these are not qualified health plans (in the exchange), he assumed that there would be no tax credit or premium support available for those individuals and **Director Deal** said that was correct. He added that the notices that companies have to send out must talk about coverage they do not have, if they go forward with qualified health plans, so that disclosure must be made when those opportunities are sent out to renew current policies.

**Representative Luker** asked about the original discontinuation letter sent out and he asked for help on the rationale for DOI requiring the discontinuation rather than just setting out the procedure for the discontinuation. If a company wanted to continue a non-qualified plan, recognizing that would not be subject to the tax credit, why was DOI requiring all policies to be discontinued? **Director Deal** said that when the bulletin was sent out in March, 2013, having to do with the transition of policies, there was no choice. Starting in January, 2014, all policies were mandated to be changed to the qualified health plans, so DOI thought it best for Idaho to transition those policies at renewal time in order to meet the mandates that these policies had to be changed. Then with the President's declaration of extension, that gave the opportunity for all citizens to keep those policies as long as they were in force before October 1, 2013. **Co-chair Cameron** clarified that carriers had the opportunity to grandfather their existing plans that were in place prior to ACA being signed. It was only those plans that were post-ACA that were forced to be equivalent to the ACA provisions. There were some carriers who decided all their plans would become compliant, a carrier choice and not a choice of DOI, and some carriers chose to keep the grandfathered plans, and those still are not required today to change. We are only talking about plans not grandfathered that were issued after ACA was signed. **Director Deal** said that if a plan was in force in March, 2010, the plan was grandfathered and so long as no changes were made in coverage, then those plans could continue on down the road. These plans were not affected at all. **Representative Luker** said his question goes to those plans created after that 2010 date and were operating as if those plans had to be discontinued, and he said he didn't read anything in the law that says they had to be discontinued, but would become non-qualified plans if continued. He asked if the Director read the law differently. **Director Deal** said that he did read it differently; DOI reads it that those plans not grandfathered, in order to be certified plans within the system at this time, had to meet requirements of essential benefits and called a qualified health plan. **Representative Luker** said he was not expecting those policies to be qualified health plans, but they were in place and he didn't read anything in ACA that said they had to be discontinued, but rather they would become non-qualified plans. If a company wanted to have a non-qualified plan outside the exchange, he didn't read in the law that it required discontinuation of any policy. He asked the Director if he read the law differently, and **Director Deal** said he did read it differently. **Co-chair Cameron** said that Tom Donovan, at a later date, can show **Representative Luker** more information on that. **Co-chair Cameron** said he believes that the law says that they had to move to qualified health plans and that the Director is forced to assure that the plans sold in Idaho from this date forward (in ACA) are required to be qualified health plans. He said

this is subject to interpretation and **Director Deal** said that he would get the information used by DOI to arrive at this point and agreed to send it to Representative Luker**. Co-chair Cameron** said that the difficulty is with the changing of definitions and rules mid-stream. **Co-chair Cameron** thanked Director Deal for his hard work in trying to do what is best for Idaho citizens. **Director Deal** thanked the insurance companies for all their hard work trying to comply with so many changes.

**Co-chair Cameron** invited three insurance carriers, representing three of the four major carriers, to share their thoughts on DOI's decision to allow reinstatement of plans canceled under the ACA. **Ms. Marnie Packard**, PacificSource Health Plans, was the first to speak, and she thanked Director Deal and DOI for working directly with carriers trying to resolve this issue. She said they were currently evaluating the impact of extending policies to customers and all consumers in Idaho. There are many unanswered questions at this time and they remain very concerned about creating future price volitility either by shifting prices too dramatically or not enough in the short-term over the next year. Their goal is to provide as much pricing stability over time as possible. DOI is working on new rules under which benefit plan extensions can be offered. PacificSource is working on certain parameters under which they would be able to continue to offer current policies. DOI is waiting for these parameters from carriers and when received, DOI will offer their final guidance, and then PacificSource will decide whether or not to extend policies. Prior to the President's decision to extend policies, PacificSource and several other carriers in the state did offer an early renewal to both individual and small group lines of business and they did receive a favorable response to that early renewal. PacificSource's decision on whether to extend will be based on what is best for Idahoans.

**Mr. Shad Priest**, Regence Blue Shield of Idaho, spoke next and he said that **Ms. Packard** had expressed it very well the current status quo, adding that Regence supports the idea of offering this option to policyholder members. He believes this is good and gives them time to digest what is going on nationally. When a policy comes up for renewal in 2014, a policyholder would have the opportunity to renew that policy into 2015, staying on that policy an additional year, rather than moving into an ACA policy. DOI he thinks was very wise doing this based on renewal dates rather than what other states refer to as the "big bang theory" such as Washington and Oregon that canceled all policies effective December 31, 2013, which sparked a huge outcry. Idaho chose a more transitional approach, but it makes it very difficult to implement. Actuaries are examining how best to accomplish this; the intent of Regence is to offer this to members, but they will work with DOI to see how this all works out.

**Mr. Dave Jeppesen**, Blue Cross of Idaho, expressed appreciation for the opportunity to address the task force and to DOI who has worked very closely with carriers in a very short time frame. He said that Blue Cross remains committed to providing continuous coverage to members and consumers as they transition to ACA. They believe as many options as possible should be available to consumers as they make that transition, which is one reason that Blue Cross decided to grandfather their entire book of business back in March, 2010. Blue Cross was delighted with the Governor's announcement making this option available and they believe this is a good option.

**Co-chair Cameron** said the members will wait to hear how the carriers decide to handle this issue and how it will be handled for consumers as things progress. He thanked the presenters.

**Co-chair Cameron** said that he did not anticipate another task force meeting before the start of session. **Co-chair Cameron** adjourned the meeting at 3:57 p.m.