MINUTES
JOINT MEETING

# HOUSE HEALTH & WELFARE COMMITTEE
# SENATE HEALTH & WELFARE COMMITTEE

**DATE:** Friday, March 22, 2013

**TIME:** 8:00 A.M.

**PLACE:** Abraham Lincoln Auditorium WW02

**MEMBERS:** Chairman Wood(27), Vice Chairman Perry, Representatives Hancey, Henderson, Hixon, Malek, Morse, Romrell, Vander Woude, Rusche, Chew

Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Guthrie, Martin, Lakey, Bock, Schmidt

**ABSENT/ EXCUSED:** Representative(s) Henderson, and Senator(s) Bock, Lodge

**GUESTS:** Larry Tisdale and Steve Millard, Idaho Hospital Association; Christine Tiddens, Catholic Charities; Jeff Cilek, St. Luke's Hospital; Elizabeth Roberts, Citizen; Woody Richards, Lobbyist; Stacy Satterlee, American Cancer Society, Cancer Action Network; Heidi Low, Ritter Public Relations; Marnie Packard, Pacific Source; Lee Flinn, AARP Idaho; Lyn Darrington, Regence Blue Shield of Idaho; Dan Alberding, Idaho Grain Producers

**Chairman Wood(27)** called the meeting to order at 8:01 a.m.

**Rep. Tom Loertscher** appeared before the committees to discuss **H 308**. He described his exposure to county indigent law, which began in 1978 when he was a County Commissioner. At that time the counties began covering state medically indigent costs, which further escalated with charity case transfers from insurance companies. Increased premature baby births and neonatal costs have consumed entire county indigent budgets. The courts defined the responsibilities beyond the county budgets, including registering warrants to be paid during the following budget year and property tax levies. The law repeal caused a medical-care gap, leading to a tax-base spread through the Catastrophic (CAT) Fund as a voluntary county option. This practice continued until the full CAT program was passed, although it was not funded the first year. The first appropriation of two million dollars continued to grow, helping counties deal with escalating medical care costs.

At a recent Board meeting, $3.7M in claims on 154 cases were approved, which is representative of one month's worth of state costs and $1.7M in county costs. **Rep. Loertscher** said the escalating costs and taxpayer property tax dollars, which is a narrow tax base, demand a program change. **H 308** would repeal CAT funding and provide, over the next ten years, about $478B in direct property tax levy relief through mandated county reductions. The CAT Funding Program imposed on the counties has become unbearable and is consuming extensive staff time to keep up with increasing cost management demands. The loss of the pre-existing condition premium payment and upcoming Medicaid sunset will escalate CAT fund costs beyond county abilities. He emphasized the costs will continue to increase, and this is the year to make the move away from the County CAT Fund.

**Chairman Wood(27)** stated that Idaho's indigent health care is funded differently than in other states and invited **Ken Roberts**, State Tax Commissioner, to help the committees understand what is happening to county charity and indigent funds.

**Mr. Roberts** described charity and indigent funds effects and the impact of the reduced maximum levy rate of 0.0002. Counties with an existing rate lower will not reflect a change. He said forty-one counties are listed, since Boise, Kootenai, and Teton Counties do not levy through the same fund. He explained the variety of levies that can be in a property tax, how the counties can use different levies for their indigent funding, and why removal of a single levy may not eliminate fund collection. Answering a question, Mr. Roberts said there is no method preventing a county from shifting levy monies between different funds.

**Rep. Loertscher**, responding to questions, said the intent of **H 308** is to reduce property taxes, since the need for that levy will be gone. It would be tough for counties to use a windfall and not provide tax relief. He does not foresee any shortcomings, due to the January 1, 2014, effective date. He compared medical care and health care systems, stating Medicaid changes are expected to help transition our current medical care system. The Pre-existing Conditions Insurance Plan (PCIP) funding has ended and the Affordable Care Act (ACA) provision still contains unknowns.

**Rep. Rusche** shared that the PCIP was a temporary ACA program for those locked out of the current insurance marketplace. It had limited federal funding and terminates January, 2014, when every eligible participant is assumed to have coverage through an exchange.

**Dick Armstrong**, Director, Department of Health & Welfare (DHW), explained how the June, 2012, Supreme Court ruling making the previously ACA mandated Medicaid expansion a state option, resulted in a fifteen-member work group that requested data collection from national consultants and experts, such as Milliman. The Governor, upon receipt of their report and recommendations, directed the DHW and work group develop a health plan model.

The work group's first recommendation is to require personal responsibility and accountability from the member/patient side of health care. To that end, they would require enforceable health care copays for everyone. Members would use a Health Responsibility Account (HRA), with healthy behavior bonus credits applied to HRAs for copay use via an account debit card. Verbal support of the developing model has been received from the Centers for Medicare and Medicaid Services (CMS).

Another recommendation is a change from the health delivery system current fee-for-service focus to outcomes and preventative care. This plan began three years ago, allows them to better manage care within the Medicaid population, and already has three successfully completed segments. Analytic systems will be deployed with each plan, so members, providers, and policy-maker communities can have transparency into the health care system, changing realized outcomes.

After describing current Medicaid eligibility parameters, **Director Armstrong** said the group most significantly influenced by ACA are adults with children. This group currently seeks care though CAT Funds, free clinics, or have no care. They will be affected by the January, 2014, change to the Modified Adjusted Gross Income (MAGI) method of household eligibility calculation.

Idaho optional enrollments affect approximately 138% of adults under the Federal Poverty Level (FPL). These are approximately 104,000 qualified adults, ages 19 to 64, who are non-incarcerated legal residents. With a $7.25 minimum wage that provides $15,000 in annual income, it becomes evident that many of these individuals will be from the workforce. Other characteristics include the presence of at least one full-time worker per uninsured family unit, ages 25 to 54, qualified Children's Insurance Program (CHIP) children, below the 100% FPL, with regular health care. They tend to use the highest cost providers, such as emergency rooms or the CAT Fund. They do not seek preventive care, have poor health habits, higher rates of tobacco use, higher rates of obesity, and a prevalence of chronic conditions. 26% of this general population experiences diagnosed mental health issues during a twelve-month period. Current sources of care for this optional population include CAT or Medically Indigent Services, Community Health Centers, Adult Mental Health Centers, and correctional facilities. **Director Armstrong** noted that the continuity of care received in correctional facilities ends upon release.

A ten-year evaluation of the status quo indicates $394M for full enrollment claims and administrative costs, for an estimated 45,848 people. No state or county offsets will be realized, so continued costs will be $539.6M CAT Fund, $109.7M state behavioral health and public health programs, and $478.1M county indigency programs.These costs also reflect a lower federal match rate of 70/30.

The evaluation of optional enrollment costs factor in 100% federal payment of enrollment claims costs for three years, decreasing to 90% by 2020. Claim and administrative costs will be $648.8M, with offset savings of $649.3M (state) and $478.1M (county). This provides a net ten-year savings of $478.6M. He described the changes in offsets that would occur if the optional enrollment is delayed six months and eighteen months, including forfeiture of federal funds.

Full and optional enrollment provides a ten-year overall cost savings of $84.6M for the General Fund and property tax payers of Idaho. This is coming out of federal tax dollars, which will change with or without Idaho's participation.

**Steve Millard**, President, CEO, Idaho Hospital Association, Member, Governor's Workgroup on Medicaid Expansion, said the group noticed that the Milliman study did not show the medical claims federal funding, so a macro-level economic study was commissioned that used a 2010 Impact for Analysis for Planning (IMPLAN) model of Idaho. They determined that the $9.2B federal funds, if not received, would have a ripple economic effect to the private sector with a loss of 16,000 jobs, $716M payroll dollars, and $614M in tax revenue.

The initial Medicaid expansion program cost of $1.042B would be offset by savings from the county indigent fund ($478M), CAT fund ($539.6M), behavioral & public health programs ($109.7M), and economic activity and tax revenues ($614M). The net savings and economic activity total is $699M. Delays will lead to a loss of funds at a rate of $54M for partial year one, $106M for year two, and $110M for year three.

The ten-year hospital ACA Medicare cuts are offset by the number of insureds increasing through mandates and the full Medicaid expansion. The Supreme Court determined that the previously required Medicaid expansion had to be optional. Idaho hospital loss, over ten years, will equal $500M, which will be shifted to insurers, employers and those who pay for their own healthcare. To make the system more affordable, hospitals are pursing accountable care organizations and leaving the fee-for-payment model.

Responding to questions, **Mr. Millard,** said data shows how much hospitals write off in charity care, bad debt, and underpayment by government payers. The $500M ten-year Medicare loss will have to shift so the healthcare system can continue.

To additional questions, **Director Armstrong** answered they are ready to act on Medicaid eligibility. They are gearing up to handle the influx of eligibility applications. They are receiving modules developed by other states, using another state's benefit design benchmark, and looking at hiring their consultant. Not everything will be overhauled by January 1, 2014. He described the efforts already underway or achieved in surrounding states.

Retraction of a health care exchange is allowed under **H 248**. It would remove any safety net and leave truly uncovered insureds without anything. **Director Armstrong** said he is requesting written confirmation, but CMS appears to be standing by verbal statements, showing they want the states to move forward with personal accountability.

**MOTION:** **Sen. Schmidt** made a motion to send **H 308** to the floor with a **DO PASS** recommendation. **Chairman Wood(27)** ruled that the motion was improper since the public has not been able to weigh in on the issue.

**ADJOURN:** There being no further business to come before the committees, **Chairman Wood(27)** adjourned the meeting at 9:21 a.m.

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| Representative Wood(27)<br>Chair | Irene Moore<br>Secretary |