MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 19, 2014

TIME: 9:00 A.M.

PLACE: Lincoln Auditorium - WW02

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

ABSENT/ EXCUSED: Representative Vander Woude

GUESTS: Mark Zaleski, IBEW; Jr. Finlay, SMWIA; Sr. Brendon Corsin, 5AHS; Corey Surber and Jennifer Palagi, Saint Alphonsus; Russ Barron, DHW; Stacey Satterlee and Elli Brown, ACS CAN

Chairman Wood(27) called the meeting to order at 9:01 a.m.

Richard Armstrong, Director, Department of Health and Welfare (DHW), presented The Idaho Option: Exploring Options for Medicaid Reform, Taxpayer Relief & Improved Public Safety. This is a free market approach using the Your Health Idaho (YHI) insurance exchange as a vehicle to provide insurance policies to low income Idaho citizens and is true Medicaid reform.

Director Armstrong described the original Affordable Care Act (ACA), which envisioned people earning between 100% to 400% of the federal poverty level (FPL) receiving tax credits to purchase insurance and people earning less than 138% FPL enrolling in Medicaid programs. Decisions from legal challenges retained the tax credits, without the Medicaid enrollment requirement. This resulted in an entire segment of Idaho citizens unable to access any insurance coverage.

Medicaid has a current enrollment of 247,000. The original design covered people with disabilities, children with special health needs, and the low income elderly. An estimated 68,000, or 28% of all current Medicaid enrollees, fall into these categories. The remaining 179,000 participants are healthy low-income pregnant women, children, and adults with children, categories later added because there were no alternatives.

Director Armstrong said the uninsured adult population range is more serious when looked at by county. Fourteen counties have adult uninsured rates over 30%. Owyhee county has a rate of 40%. Latah and Madison counties have the lowest uninsured rate of 19%.

The free market approach uses qualified health plans from the YHI for low-income adults who are not eligible for Medicaid. Federal dollars pay the premiums. The Centers for Medicare and Medicaid Services (CMS) has approved free market approach demonstration pilot projects in Arkansas and Iowa, with Pennsylvania nearing approval, which cannot cost more than traditional Medicaid coverage. Arkansas was able to use all of their indigent and catastrophic funds as part of the formula, which makes it a reasonable and realistic direction for Idaho's waiver application.

In this approach, the DHW would make direct payments to the insurers. This differs from the Exchange insurers, who receive premium and subsidy payments from different sources. Premium payments are 100% federally funded until 2017, at which time the state begins paying a 5% share from the General Fund. This state share increases to 10% in 2020. If the plan levels change, enabling fail safe language would stipulate an immediate sunset. A minimum offering of two silver medal level plans will allow participants a choice.

The current screening process would be applied to assure truly medically fragile individuals are in Medicaid, following the program's true intent, and assuring insurance companies maintain their low rate advantage.

In further describing the private option, **Director Armstrong** said it significantly increases marketplace enrollees, encourages private carrier entry, expands service area access, and results in more competitive pricing. It also reduces churn between Medicaid and health plan coverage, particularly when an individual's employment or income level are reduced.

The Medical Indigency Program covers post-incident care. Counties pay the first $11,000 in claims and the state pays the balance. Recent reviews indicate an increase in claims exceeding $1 million by individuals at 300% FPL who are unable to pay off their debt in five years. The state and county combined costs for 2013 equaled $53 million and are expected to reach $92 million by 2020, unless something is done.

A Milliman actuarial analysis estimates Idaho could save 90% to 95% of the combined indigency costs with the private option coverage. This would result in a savings of $425.3 million from 2016 to 2020. Additional Medicaid costs from the ACA requirements for the same time period are expected to be $171.3 million. Costs and savings are estimated to equal a $102.9 million savings. Through the private option free market approach, Idaho could save more than $100 million by 2020 while insuring 104,000 individuals.

Behavioral Health Crisis Centers address a constant law enforcement limitation when dealing with individuals acting out in their communities. Officers currently have only two choices: incarceration; or, transport to a hospital emergency room (ER). If transported, the officer must remain with the individual until an assessment is done, which usually takes hours beyond the travel time. Crisis Centers allow stabilization and de-escalation of individuals. They connect patients with community resources so they can return to their homes, jobs, and prevent future crises and recidivism. The three centers, modeled after successful programs in other states, would be located in the panhandle, southeast, and southwest portions of the state. Provided start up funding would help contract the operations to community stakeholders. Oversight would be through a Community Board that would also develop a sustainable operations plan. Private providers and case workers would work with individuals in and out of the centers.

The Justice Reinvestment Initiative relies on behavioral health treatment. **Director Armstrong** described the initial sentencing and probation focus that revealed a growing recidivism and prison return problem due to mental health and substance abuse issues. By January, 2014, all health policies must have equal health benefits, including mental health coverage. He said this is an opportunity to prevent individuals returning to prison by involving them in treatment within their communities.

Responding to questions, **Director Armstrong** explained the available federal waiver being considered would fund the cost sharing within the benefit design of the ACA, providing a benefit subsidy for individuals who are below 250% FPL at the time of their claim. CMS has approved use of waiver monies, so there is no need for additional state dollars until 2017. The waiver cost parameters would be a challenge, which is why review of other state analyses is important to determine how to arrive at the neutrality amount.

There is no anticipated discontinuation of the Children's Health Insurance Program (CHIP). A family enrolled in a private insurance product, if faced with a qualifying low-income pregnancy, would probably not change their healthcare program. It is important to assure the assessment process places medically fragile individuals in the Medicaid program and not accidentally into private insurance. Since the mechanism to handle their specific needs is complicated and already in place, the modified Medicaid population is expected to be maintained in the current program.

Responding to further questions, **Director Armstrong** explained the Milliman analysis of state incurred costs indicated a shift to a quality of care business could be done immediately. Further evaluation of areas that could be moved to private insurance, along with increased general fund costs resulting from previously Medicaid eligible individuals now enrolling, emphasized the efficiency in moving costs to a more organized system of delivery.

Federal waivers are for a duration of five years. Previous waiver experience shows they are good for their duration, as long as there is no deviation, the performance continues, and the rules of engagement are demonstrated. The waiver surety is encouraging, especially when using similar language to that used by states granted the waiver. Since three states have been approved, there is an element of urgency to apply for the waiver because CMS can determine enough waivers exist to cover the demonstration.

A state plan amendment (SPA) is a structured benefit design. The federal waiver gives time to prove the value of an SPA and establish citizens would not be abandoned by pursuing this benefit design.

Answering further questions, **Director Armstrong** said unhealthy risk recognition assures individuals are in the appropriate plan and not sent out into private industry. Eventually the private industry will have guidelines to manage these complicated risks effectively.

All Exchange applications await review in the "queue" and may end up in the Exchange, Medicaid, or be ineligible. Individuals falling within the "gap" of ineligibility are being identified for future notification when an option becomes available.

Since the economic downturn, indigency claims have broadened to include chronic diseases and normal medical items like broken bones. This further indicates the economic state of households and rising healthcare costs. The Association of Counties is identifying the mill levy portion of the CAT and Indigent Programs in order to maintain their ability and responsibility to address other assistance needs, such as rent and energy, when the programs cease.

Insurance company executives had to set plan rates prior to implementation of the Exchange. Within insurance rating boundaries are factors that impact the rates, such as subsidized rates and higher premiums for older individuals. One third of individuals in any insurance cell submit zero claims in a year. Not surprisingly, 10% of the population uses 50% of the resources, but the demographics are looking good.

ADJOURN: There being no further business to come before the Committee, the meeting was adjourned at 10:37 a.m.

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Representative Wood(27)
Chair

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Irene Moore
Secretary