MINUTES

SENATE COMMERCE & HUMAN RESOURCES COMMITTEE

DATE:	Tuesday, January 27, 2015
TIME:	1:30 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Tippets, Vice Chairman Patrick, Senators Cameron, Martin, Lakey, Heider, Lee, Schmidt and Ward-Engelking
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Tippets** called the meeting to order at 1:30 p.m. and welcomed everyone to the Committee.

PRESENTATION: **Pat Kelly**, Executive Director, Your Health Idaho (YHI) gave an update on accomplishments as a state-based marketplace and the transition in running a technology platform this fall. The 2014 Annual Report will be published at www.yourhealthidaho.org. **Mr. Kelly** said that in 2010, Congress passed the Affordable Care Act (ACA) which required each state to establish a health insurance exchange or have the federal government run one in the state. To limit federal intervention in Idaho, to maintain control of Idaho's health insurance market, and to save Idahoans money, the Legislature voted to create a state-based exchange (Exchange) in Idaho in March of 2013. That marketplace is now known as YHI. YHI is meeting the goals set forth in H 248, that were placed in front of the YHI Board (Board) and staff less than two years ago. YHI is preventing federal intervention in Idaho and is providing a much needed resource to thousands of Idahoans who want health insurance. Most importantly, by establishing local governance, YHI has been able to run a more efficient exchange than the federal government, which has saved money while still fulfilling the needs of YHI customers. In comparison to states where the federal government is running an exchange, Idaho is benefiting in many areas, but in particular because the Board sets the requirements for plans on the Idaho Exchange. At the recommendation of the Idaho Department of Insurance (DOI), the Board certifies that all plans sold on the Exchange meet those requirements.

Mr. Kelly reported that agents and brokers are the primary resource for consumers, and there were already over 1,000 licensed agents and brokers helping Idahoans find the right plan to fit their needs. In federally-managed states, agents and brokers have limited roles. Consumer assisters are chosen and make consumer protection a top priority. Organizations are hand picked who can best represent and help Idahoans. Enrollment counselors undergo a rigorous background check. In federally managed states, the federal government selects and funds organizations to assist consumers.

Mr. Kelly said the initial assessment fee is 1.5 percent. In federally-managed states, assessment fees are higher. The Exchange is governed by a board of Idahoans. The Board determines how funds are used and how the marketplace is implemented. The Exchange can respond quickly to the needs of consumers, whereas in federally-managed states, residents must go through federal bureaucracy. The Exchange is a great example of Idahoans helping Idahoans. **Mr.**

Kelly commented what has been accomplished over the last two years to benefit thousands of Idahoans is remarkable.

When the Exchange was established there was a 19-member board of volunteers with the duty to keep control of the Exchange. There was no staff, funding, infrastructure, governance, office space or computers, and there was a deadline of only six months to start up an Exchange. There was so little time that it was clear the Exchange had to borrow the healthcare.gov technology for the first year. They did so while maintaining their status as a state-based exchange and the benefits afforded to the Exchange. The benefits of that status are about more than running their own technology system. Maintaining the state-based exchange status allowed the Board to keep control of the decisions about the Exchange and keep costs low; keep the federal government out of Idaho's insurance market; and maintain a primary role for agents and brokers in selling health insurance, which allows the Exchange to respond quickly to the needs of consumers even when technology is not working.

In fact, **Mr. Kelly** said, the foundation for success was the ability to maintain a primary role for the real experts on health insurance, which are the agents and brokers. They have been pushed aside in other states where the federal government operates an exchange. Agents and brokers have been trusted resources in communities across Idaho for decades and are the best front line of support to help consumers navigate through the plan options. Agents and brokers make the system work and more than half of the enrollments through YHI were assisted by an agent in-person assister.

Most importantly, in year one, the Exchange worked for 76,061 Idahoans who enrolled in coverage between October 1, 2013 and March 31, 2014. The State saw the third highest enrollment per capita in the country. This was in large part due to having agents and brokers available for citizens when the healthcare.gov technology did not work or when they needed help understanding the tax credit process or picking a plan. With a federal exchange, the agents and brokers would not have this primary role and those that chose to use the Exchange would not have had the correct local resources available to make an informed decision. The first open enrollment period in April was very successful. The rest of 2014 and the beginning of 2015 has been one of challenge, transition and significant accomplishment.

Mr. Kelly reported that in year two, in addition to continuing to maintain control and provide consumers with the tools and resources they needed to make an informed decision, YHI has become the first health insurance exchange in the nation to successfully migrate from the federal exchange technology platform to one run here in Idaho. This launch did not come without challenges. There were delays in receiving the data from the federal government, changes in requirements to re-enroll customers that signed up last year, and changes in requirements tied to the use of grant funding. However, status as a state-based exchange with operations under direct control, enabled YHI to act quickly to find resolutions while keeping the assessment fee low and maintaining robust choices for consumers.

The year 2014 focused on the design of the technology system and how applications would be processed and customers would be enrolled. In designing the system, YHI partnered with the Department of Health and Welfare (DHW) to process eligibility for tax credits. The next step was to move all 76,000 enrollees from the healthcare.gov platform to YHI and reprocess their tax credit eligibility. As a state-based exchange, YHI recognized that it was very important to reprocess tax credit eligibility for all customers to ensure they were receiving the appropriate amount of tax credit. **Mr. Kelly** reported the federal technology system had no safeguards to ensure the tax credits Idahoans received in 2014 were accurate. The data came later than expected from the federal government and with many errors. However, the DHW took the available data and reprocessed everyone's eligibility to determine accurate tax credits that could be applied to consumer premiums in 2015. Consumers then received a notice of their eligibility for tax credits and other cost-savings for 2015.

The technology platform is working. However, the Exchange has experienced and addressed a few challenges. **Mr. Kelly** explained that first, after DHW redetermined eligibility for the 76,000 insureds that had coverage in 2014, agents and customers had some challenges linking the eligibility determinations to their accounts so they could enroll with the right tax credit applied. This led to demands on the call center being higher than anticipated. Some customers and agents experienced delays in getting their questions answered. As a state-based exchange, with operations under the control of the Exchange, in a few short weeks working with partners at DHW, additional staff was trained and deployed to reduce wait times and to help consumers and agents correctly link the eligibility determination to their accounts. As enrollments continue to be processed for the 2015 open enrollment period, YHI is working through reconciling some challenges with carriers involving duplicate enrollments and terminations. No technology launch is perfect. YHI anticipated there would be bumps in the road, but is confident that the right experts are in place to quickly handle these issues.

Mr. Kelly said another highlight this year is that YHI has maintained and grown a network of over 1,000 agents and brokers who have completed training on YHI and who have the primary role of helping consumers shop for and select a plan on YHI. This represents a 30 percent increase in agents participating in the Exchange from last year. As the Exchange moves toward financial sustainability in 2016 and there are fewer resources available for broad-based outreach, agents and brokers will be vital to help retain current customers and continue to enroll new customers that enter the market. These agents also work closely with the 94 enrollment counselors from hand-picked community organizations across the State, who help educate customers about their options and often refer them to agents and brokers to assist with final plan selection.

In addition to being able to quickly respond to the needs of customers by maintaining local control, costs have been kept significantly lower than the federal exchange and most state-based exchanges by building an exchange that is right-sized for Idaho. **Mr. Kelly** compared the Exchange to a start-up business. He said navigating through the rules and regulations for federal grant funds in 2013, 2014 and through the end of 2015 was a challenge. The Exchange has been treated as a capital investment that will put the Exchange on a path to long-term financial sustainability. These funds have been used to invest in the technology system and in making customers aware of the tools and resources available through the Exchange. By using vendor expertise and resources to build the technology system and infrastructure, YHI has kept staff count low which will enable the Exchange to easily transition into maintenance and operation mode

with low on-going overhead costs. This approach will serve as the foundation for YHI's financial sustainability period which will begin on January 1, 2016.

Most Idahoans are eligible to use YHI if they choose to shop, compare and choose a health insurance plan. To be eligible to use YHI, Idahoans must live in the United States, be a United States citizen or national (or be lawfully present) and cannot currently be incarcerated. Those with Medicare coverage are not eligible to use YHI to buy a health or dental plan. In addition to being a place to shop for health insurance from multiple private insurance companies, YHI is the place where consumers can go to determine if they are eligible to receive a tax credit or cost-sharing reductions to lower their costs. To be eligible for cost-savings programs, consumers must be eligible to shop on the Exchange, have an income and family size that falls within the ranges ($11,670-$46,680 for individuals, $15,730-$62,920 for a family of two, $19,790-$79,160 for a family of three, and for a family of four $23,850-$95,400), and not have access to affordable coverage through an employer or other government program such as Medicaid or the Children's Health Insurance Program (CHIP).

Mr. Kelly said a large majority of Exchange shoppers have enrolled with a tax credit, and price and availability of tax credits seem to be the biggest motivators for enrollment through YHI. As a result, a majority of outreach efforts have focused on the population that is tax credit eligible. In 2014, nearly 9 in 10 Idahoans who enrolled in coverage had a tax credit applied to lower their cost of insurance. This year's numbers are still incomplete as there are a few more weeks of open enrollment. Currently, three-quarters of enrollments are for those who are seeking a tax credit.

Mr. Kelly pointed out that price and value were a key motivator to purchase. Both this year and last year over 70 percent found great value and elected to enroll in a silver plan. Customers using silver plans that fall in the right income range can be eligible for both a tax credit and also lower out-of-pocket costs on things such as co-pays, coinsurance and deductibles. Platinum plans, which have the highest monthly premiums, have not been as popular. Bronze plans have some of the lowest monthly premiums, but the customer has to pay more when they go to the doctor or use a medical service.

The 'young invincible population'; those between the ages of 18 and 34, make up approximately 27 percent of enrollments. This age group is very important as having younger and generally healthier adults helps balance the risk pool and helps to keep premium prices stable and lower over time. Young people signing up also support the long-term sustainability. If customers can be retained, they are potential long-term clients who YHI can continue to educate on the value of insurance.

Mr. Kelly said looking to 2015, the primary goals for the Exchange are to continue to make prudent financial decisions to be prepared for financial sustainability starting on January 1, 2016; to maintain and enhance the technology system to provide an even better experience for customers; and to retain approximately 80 percent or more of customers each year in order to support financial sustainability.

He said he did not know if the assessment fee would be increased. He noted that was a decision that would come from the Board and would be discussed openly in the coming months.

Automating technology functions and improving the consumer experience are important as the ease of use and automation of the system will impact operational costs and the ability to be financially sustainable. More automated functions

reduce the operational need for support, thereby reducing on-going operational costs. These enhancements include items such as further automation of eligibility determination, online change reporting or a carrier rate review tool. YHI is looking at using remaining federal grant funds to invest in these enhancements and others, with an eye towards maintaining compliance to keep control of the Exchange, cost and need.

The more functions that can be automated the lower the need for customer service representatives and expending resources on consumer assistance. There will always be a need for consumer assistance, and YHI wants to do everything they can to make agents and brokers self-sufficient to reduce the need for YHI resources and to assist with the application and enrollment process. This involves using part of the grant funding this year to invest in continued training of agents and brokers and development of tools, job aids and resources to assist consumers.

Retention of current customers will be key to the success of the Exchange. In the first two years, outreach efforts have reached most of the 130,000 consumers that are eligible for tax credits. The strategy will be evaluated when the totals at the end of this open enrollment period are received. YHI anticipates that the focus will be keeping the current customers moving forward. It is anticipated in 2016 and beyond approximately 80 percent of enrollments will be from retention of existing customers and 20 percent will be new enrollments from those that are tax credit eligible and new to the market because of moving or other life changing events.

YHI has achieved great things in the last two years and is working for over 80,000 Idahoans. They have maintained control of the Exchange, prevented federal government intervention, and, most importantly, administered a more efficient program. This has saved consumers money while also putting the Exchange on a path to financial sustainability.

Vice Chairman Patrick wanted to know the definition of tax credits. **Mr. Kelly** explained the credit is an advanced tax credit and it is reconciled when the consumer files their taxes.

Senator Martin asked for an explanation of the roles of an in-house assister, navigator, broker and agent. **Mr. Kelly** explained agents and brokers are licensed in the State. They are certified through YHI. In-person assisters and navigators are enrollment counselors who educate the consumer. There are seven enrollment counselors in the State. They are not allowed to recommend a plan. **Senator Martin** and **Mr. Kelly** discussed the possibility of a change in the future of the assessment fee of 1.5 percent.

Senator Schmidt and **Mr. Kelly** talked about cash reserves of $117.1 million for the second grant. **Mr. Kelly** elaborated and said YHI has received three federal grants. The first two were awarded in 2013 and the third was awarded in December of 2014. YHI has $17 million remaining from the first two grants. The third grant is not included in those figures. The value of the third grant is $35 million. Grant funds that are available is $52 million. The cash reserves are separate and distinct from the grant funds. He explained the 1.5 percent assessment on plans through the Exchange since open enrollment last year has been held in reserve by YHI and will be held in reserve until the sustainability period beginning in January 2016. **Mr. Kelly** said there are approximately $3 million in cash reserves. **Senator Schmidt** and **Mr. Kelly** discussed the 146 plans available on the Exchange in 2014 and the increase in 2015 to 198 available plans. They also talked about the increase in the number of carriers. **Senator Schmidt** and **Mr. Kelly** discussed the premium rate changes as they related to each individual family situation. They talked about the popular silver plan, and **Mr. Kelly** pointed out there was a general range in the

premium rate ranging from a 12 percent decrease up to a 9 percent increase.

Chairman Tippets commented there was anticipation more plans would be offered than the federal exchanges. He was pleased to hear there are currently 198 plans offered. He commented about the consumers who were pleased with their plans. He wanted to know if there had been complaints from people who were receiving an increase in medical insurance premiums. **Mr. Kelly** said YHI has heard concerns, but complaints could be because of a change in the household composition, moving, or a number of different factors.

Chairman Tippets and **Mr. Kelly** discussed whether or not federal subsidies were available to federal and state exchanges due to pending litigation. **Mr. Kelly** indicated the state-based status should not be affected because Idaho has maintained its status as a state-based exchange.

Senator Schmidt said he has heard complaints about the difficulty of finding a high deductible plan. He asked for a description of the limits of a high deductible plan. **Mr. Kelly** answered there were nine essential health benefits that every plan has to contain. The plans are reviewed by the DOI.

Vice Chairman Patrick wanted to know what the federal exchange charged for an assessment fee. **Mr. Kelly** explained the federal assessment fee was 3.5 percent and Idaho charged 1.5 percent.

Senator Cameron remarked he has used the system repeatedly this year and it is far more responsive than the federal system. He found the in-house assisters and navigators to be responsive and very easy to work with. He referred to the question that Senator Schmidt asked and said the highest deductible plan that he recalled being available was the $6,350 plan. The typical bronze plan is a $5,000 deductible plan and has some adjustment depending upon the type of plan, the company, and the location. The figures can adjust over time. The maximum out-of-pocket was also $6,350. Those who choose that deductible end up with a 100 percent benefit after the deductible is met. As soon as the figures are entered into the estimator, the plans are shown, including the high deductible plans. There was a slight increase in most of the plans and some did not experience an increase. He thanked the YHI for all of their hard work.

PASSED THE GAVEL: Chairman Tippets passed the gavel to Vice Chairman Patrick to introduce the presenters for the rules review.

DOCKET NO. 17-0204-1401: **Industrial Commission Worker's Compensation Law - Benefits**. **Matt Vook**, Benefits Analyst, Industrial Commission (Commission) explained the rule allows for the reimbursement of health care travel expenses of an injured worker who attends necessary medical appointments as a result of an industrial injury or occupational disease, pursuant to Idaho Code § 72-432, Section 1. The rule removes the form for the reimbursement of health care travel expenses from the actual rule and directs the injured worker to the Commission address or website to obtain the form. Negotiated rulemaking was not conducted because a subcommittee of the Commission's Advisory Committee (CAC), which included representatives of insurance carriers and medical providers, had been providing input to the Commission on the issue.

MOTION: **Senator Tippets** moved to approve **Docket No. 17-0204-1401**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 17-0206-1401: **Industrial Commission Employers' Reports**. **Matt Vook**, Benefits Analyst, Industrial Commission (Commission), explained the rule eliminates the language that extends the deadline for filing a summary of payments for adjusters who do not make timely indemnity payments; it changes the time period from 60 days to 120 days to file a summary of payments in case of default by an employer for reason of insolvency or bankruptcy. Negotiated rulemaking was not conducted because a subcommittee of the CAC, which included representatives of insurance carriers and self-insured employers, has been providing input to the Commission on the issue.

MOTION: **Senator Schmidt** moved to approve **Docket No. 17-0206-1401**. **Senator Ward-Engelking** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 17-0208-1401: **Industrial Commission - Miscellaneous Provisions**. **Matt Vook**, Benefits Analyst, Industrial Commission (Commission), indicated the rule provides the Commission's mailing address; removes the form notice to claimants of a status change, pursuant to Idaho Code § 72-806, from the actual rule; and directs the constituent to the Commission address or website to obtain the form. Negotiated rulemaking was not conducted because a subcommittee of the CAC, which included representatives of insurance carriers and self-insured employers, has been providing input to the Commission on the issue.

MOTION: **Senator Schmidt** moved to approve **Docket No. 17-0208-1401**. **Senator Ward-Engelking** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 17-0211-1401: **Industrial Commission - Under Workers' Compensation Law - Security for Compensation - Self-Insured Employers**. **Jane McClaran**, Financial Officer, Industrial Commission (Commission), stated the rule is needed to implement the qualified exception requirements of self-insured employers under Idaho Code § 72-301A. The rule also confers a benefit to existing self-insured employers by allowing the application of an Experience Modification (E-Mod) when calculating premium tax payments. Pursuant to Idaho Code § 67-5226(1)(b) and (c), the Governor has found that temporary adoption of the rule is appropriate. The rule is necessary to comply with the requirements of Idaho Code § 72-301A, for employers at Idaho National Laboratory (INL) working under a cost-reimbursement contract with the federal government. It allows the self-insured employer to apply for an E-Mod rating from the National Council on Compensation Insurance (NCCI) for use in its premium tax filing in compliance with Idaho Code § 72-523.

Negotiated rulemaking was not conducted because the rule complies with the requirements of Idaho Code § 72-301A, requiring the Commission to adopt rules governing the administration of employer self-insurance.

Ms. McClaran reported the new code is specific to INL contractors working under a cost reimbursement contract with the federal government. She added that under Section .014, Subsection .02, the Commission addressed in rule the practice of requiring a surety company issuing a surety bond to be independent from the principal self-insured employer for which the bond is issued.

Finally, the proposed addition of Section .015 allows self-insured employers to elect to apply the NCCI for an E-Mod factor. The factor may then be applied to the Idaho premium tax computation, effective with calendar year 2014.

Vice-Chairman Patrick wanted to know how many self-insurers there are in the State. **Ms. McClaran** said there are 28.

Senator Cameron and **Ms. McClaran** had a conversation regarding the change in the rule. They discussed whether the INL was satisfied with the rule. **Ms. McClaran** emphasized this rule would allow future contractors to be eligible immediately, rather than operating on the site for a period of years. They discussed the lack of negotiated rulemaking and if there was any opposition to the rule. **Ms. McClaran** said this rule was implementing what was passed last session unanimously by the Legislature. She said there was no opposition to the rule. **Ms. McClaran** said premium tax was assessed. The Commission worked very closely with the State Insurance Fund and refunded a part of the premium tax.

Chairman Tippets asked Ms. McClaran to explain to him why this was a pending rule and yet, there was temporary rule justification from the Governor's office. **Ms. McClaran** explained that because the statute was passed last Session, changes were being implemented to comport to the new law. She said the E-Mod was added and was conferring the benefit. This was one of the criteria required by the Governor's office in order to qualify as a temporary rule. She explained the three criteria to be eligible for a temporary rule: 1) necessary to protect the public health, safety or welfare; or 2) compliance with the deadlines in amending of governing law or for federal programs, which is the case with the exceptions to qualifications; or 3) conferring a benefit, which is specific to the ability to use E-Mod. They discussed the effective date and how the docket was treated as a pending rule, which will not be in effect until the end of the Session if approved by the Legislature. Parts of the rule that were temporary were also discussed. **Tom Limbaugh**, Commissioner for the Commission, indicated part of the rule was temporary, and the issue came up in the House and Dennis Stevenson, Coordinator, Administrative Rules, answered the question.

Chairman Tippets and **Ms. McClaran** talked about a specific exemption for an employer at the INL site who has a reimbursement contract with the federal government. They talked about the requirement for a $4 million payroll. **Ms. McClaran** commented the likelihood of an employer having a cost-reimbursement contract with the federal government that is so small that they have less than a $4 million payroll was very unlikely. The reason the threshold remained the same was because there was a desire to have a sophisticated employer to consider self-insuring.

Chairman Tippets wanted to know why the E-Mod factor was implemented. **Ms. McClaran** said Idaho Code § 72-523 requires that self-insured employers pay premium tax based on the premium the employer would be required to pay the State Fund if the employer obtained a work comp insurance policy through the State Fund. The State Fund allows an E-Mod in determining premium tax. Depending on the employer's experience, the tax could be more or less and that is why this rule was written.

MOTION: **Senator Martin** moved to approve **Docket No. 17-0211-1401**. **Chairman Tippets** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 17-0209-1401:

Industrial Commission - Medical Fees. **Patti Vaughn**, Medical Fee Analyst, Industrial Commission (Commission), said this rule implements an update to the facility fee schedule to reflect market conditions. A change to the Current Procedure Terminology (CPT) code range affecting psychiatric diagnostic evaluations is made to align with coding changes implemented by the American Medical Association (AMA). The allowable period for prompt payment by a payer is changed to commence upon acceptance of liability if made after receipt of the provider's bill. Negotiated rulemaking was not conducted because a subcommittee of the CAC, which included representatives of insurance carriers and medical providers, has been providing input to the Commission on the issue. A change in reimbursement for certain hospital outpatient diagnostic lab services is made to align with a change made by Centers for Medicare and Medicaid Services (CMS).

Ms. Vaughn reported there are two main components to the Resource Based Relative Value Scale (RBRVS). CMS assigns each coded medical procedure a numerical Relative Value Unit (RVU) based on the expenses associated with providing that service and a monetary conversion factor determined by the Commission. The allowed amount is the assigned RVU multiplied by the corresponding conversion factor.

The range adjustments appearing in Medicine Groups 1 and 2 are housekeeping in nature, regrouping some psychiatric diagnostic evaluation codes to keep similar services reimbursed at a similar rate. This is done to align with coding changes implemented by the AMA.

Ms. Vaughn reported that for the second year in a row, no adjustment has been proposed to the physician conversion factors. The Commission is sensitive to the need to preserve access to primary care for injured workers. Over the last few years the Commission has focused their efforts on reducing both the number of conversion factors and the disparity between the surgery and medicine categories. However, the Commission did not find an increase to be warranted based on an analysis of available charge data. The data revealed that 85 percent of the units billed for the most frequently billed office visit code (CPT code 99213) were billed below what the fee schedule currently allowed. Rule 17-0209-0301(a) limits reimbursement to the lower of the calculated fee schedule amount or as billed by the provider, or the charge agreed to pursuant to written contract. Industry reports consistently show the Idaho fee schedule to be among the nation's highest. The CAC recommended no change to the physician rates for fiscal year (FY) 2016. The decision to freeze physician reimbursement rates for another year prompted dozens of physicians to request a public hearing, which was granted on November 13, 2014. Most of the testimony received stated that family practice physicians were providing primary care at a lower cost than what would be allowed for the same care in a facility setting. Physicians also testified that their costs were rising. The bottom line is the Commission cannot justify an increase when the data shows most physicians are billing below what is allowed. Preserving access to physicians remains the Commission's priority. The Commission intends to seek new data this year and reassess the need to adjust the physician fee schedule based on that data.

Chairman Tippets discussed the negotiated rulemaking process with **Ms. Vaughn**. **Ms. Vaughn** said the reason for not conducting negotiated rulemaking was because there was a general consensus of the subcommittee and there was a broad representation of stakeholders. **Chairman Tippets** stated that the Commission should conduct negotiated rulemaking whenever feasible, even though that has not been the practice. **Vice Chairman Patrick** said he agreed.

Ms. Vaughn continued with her presentation. She said hospital payments were calculated as the relative weight that is assigned by CMS multiplied by the base rate set by the Commission. She pointed out that a 2 percent rate increase has been proposed for hospital inpatient and outpatient services and for ambulatory surgery centers. The facility fee schedule was first implemented in January 2012. This is the first adjustment since implementation. The base rate for hospital inpatient services is increasing from $10,000 to $10,200; the hospital outpatient base rate is increasing from $138 to $140.75; and the base rate for ambulatory surgery centers is increasing from $90 to $91.50. These increases were adopted with the recommendation of the CAC.

Additional housekeeping changes have been added to allow reimbursement for hospital outpatient diagnostic lab services when performed separate from any other outpatient services. This change was necessary due to a change made by CMS that bundles payment of these services into other payments.

Insurance company payers are required to issue payment within 30 calendar days of receiving a medical bill, but sometimes a payer receives the bill before receiving notice of the claim from the employer. This change allows a payer 30 calendar days from acceptance of liability if made after the bill is received from the provider. With this change, the clock will not begin ticking for the payer until they know there is actually an industrial claim.

Senator Cameron asked for an interpretation of outpatient lab tests relating to reimbursement for hospital outpatient services. **Ms. Vaughn** explained that Medicare made changes that bundled payments and paid the bill inclusive with other items on the invoice. Hospitals would bill for diagnostic labs, but because of the status code, they were not eligible for payment. With the new modifier, the provider can bill diagnostic labs and will be eligible for payment.

Senator Cameron asked about the potential unintentional consequences of the wording. He cited an example of tests being run on a worker who had to go to the hospital and an outside service reads the Magnetic Resonance Image (MRI). In the process the patient had to be life-flighted to another hospital, and the doctor ordered another MRI. He wanted to know if the carrier would be allowed to pay for the MRI twice. **Ms. Vaughn** said that since they were two different hospitals both MRIs should be paid.

MOTION: **Chairman Tippets** moved to approve **Docket No. 17-0209-1401**. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 17-0209-1501: **Industrial Commission - Medical Fees - Temporary Rule**. **Patti Vaughn**, Medical Fee Analyst, Industrial Commission (Commission) reported the Idaho workers' compensation hospital outpatient fee schedule is modeled after the Ambulatory Payment Classification (APC) payment system created by Centers for Medicare and Medicaid Services (CMS). After the Commission adopted proposed rules for FY 2016, CMS published a final rule implementing coding changes for some hospital outpatient surgical encounters that would significantly increase payments if implemented with the existing language in the rule. In order to keep payments stable and to avoid unnecessary confusion, the Commission adopted this temporary rule extending the use of the 2014 relative weights. The Commission intends to address the conflict in a more permanent fashion during the next rulemaking cycle.

MOTION: **Senator Cameron** moved to approve **Docket No. 17-0209-1501**. **Senator Heider** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 17-0501-1401:	**Industrial Commission - Rules Under the Crime Victims Compensation Act** was continued to another meeting, due to the lack of time.
PASSED THE GAVEL:	Vice Chairman Patrick passed the gavel back to Chairman Tippets.
ADJOURNED:	There being no further business, **Chairman Tippets** adjourned the meeting at 2:56 p.m.

Senator Tippets
Chair

Linda Kambeitz
Secretary