Subject to approval by the Task Force

HEALTH CARE TASK FORCE
CORRECTED MINUTES

Tuesday, September 12, 2006
State Capitol, JFAC Room
Boise, Idaho

The meeting was called to order by **Cochair Representative Bill Deal** at 9:10 a.m. Other Task Force members present included: Cochair Senator Dean Cameron, Senators Joe Stegner, John Goedde, and Kate Kelly, and Representatives Kathie Garrett, Gary Collins, Sharon Block, and Margaret Henbest. Senator Dick Compton, Senator Tim Corder and Representative Max Black were absent and excused. Paige Alan Parker, Katharine Gerrity and Charmi Arregui of Legislative Services staffed the meeting.

Others in attendance included: Therese Bishop and Tim Olson, Regence; James Schroeder, Idaho Primary Care Association (IPCA); Blake Hall, Catastrophic Health Care Cost Program; Tony Poinelli, Idaho Association of Counties (IAC); Julie Taylor, Blue Cross of Idaho; Jill Reese, Taryn Magrini, Idaho Community Action Network (ICAN); Beth Foster, BSU Nursing; Corey Surber, St. Alphonsus; Woody Richards, Ted Roper, Department of Administration; Tom Shorn, Laren Walker, AmeriBen; Patti Campbell, Paul Leary and Kate Vanden Broek, Department of Health and Welfare, Medicaid; Tom Donovan, Donna Daniel and Mindy Thede, Department of Insurance/Attorney General's Office; Jim Baugh, Co-Ad; Paul Leary, Department of Health and Welfare; Teresa Molitor; Lon Perin, AARP; Molly Steckel, Idaho Medical Association; Toni Lawson and Carla Terry, Idaho Hospital Association; Kathy Coumerich, John Watts, Jesus Blanco and Rachel Wheatley, Idaho Primary Care Association; Ned Parrish, Office of Performance Evaluations; Linda LaMott, Idaho Association of Health Underwriters; Erin Bennett, March of Dimes; Steve Tobiason; Cathy Holland-Smith, Legislative Services, Office of Budget and Policy; and Bob Seehusen, Idaho Medical Association.

A motion was made by Representative Collins to approve the minutes from the February 14, 2006 meeting, seconded by Senator Stegner, and the motion passed unanimously by voice vote.

A. Presentations

1. Ms. Cathy Holland-Smith, Division Manager, Office of Budget and Policy, Legislative Services

Ms. Holland-Smith distributed a handout titled "Data Reported by Idaho Counties to the Catastrophic Health Care Cost Program (CAT)," also called the Medically Indigent Health Care Program, a copy of which is available in the Legislative Services Office. The report contains a compilation of data from fiscal year 2002 to fiscal year 2005, reflecting who uses the system, how funds are paid through partnership with the counties and providing an appropriations history.

Ms. Holland-Smith explained how the indigent health care system is impacted by a "safety net" for health care for the uninsured and the underinsured. This "safety net" is funded in Idaho from direct appropriations to the Catastrophic Health Care Program in partnership with the counties. The counties pay the first $10,000 over a 12-month period per individual. Once that $10,000 deductible has been met, the state picks up any additional cost. Funding is also provided for the "safety net system" through the Medicaid Program. For community health systems that are federally qualified, the state pays a flat rate for every service provided to a Medicaid-eligible individual. A portion of that flat rate helps subsidize health care for other persons not eligible for Medicaid. There is also a Medicaid "DSH" (disproportionate share of a hospital's payment) that is made directly through the Medicaid Program to hospitals in Idaho to compensate them for those persons who are either uninsured or under insured. According to **Ms. Holland-Smith**, Idaho is paying the DSH in the amount of $16 million and that is projected to go to $18 million, or 30% general funds, in FY 2008. She emphasized that when one piece of the system changes, it impacts other parts of the system. There are also other federal funding sources that include direct grants to community health centers and Medicare.

Ms. Holland-Smith said that the largest payers of the "safety net" are people who are insured. Any person in Idaho who has health insurance is in some way subsidizing the difference in the health care costs that are not covered either by the DSH or the catastrophic or indigent health care system.

Ms. Holland-Smith next addressed the budgeting process. The administrator of the Catastrophic Health Care Program submits a budget request each September 1st to the Legislature and the Division of Financial Management along with an annual report, listing by county and by indigent number (not a name) how much was paid out for that individual for the previous fiscal year and the first six months of the current year. All reimbursements by individuals are accounted for by county as well. Individuals have five years to repay the money.

The final portion of that annual report shows categorically how payments were made. The appropriation process utilizes base budgeting which works well if needs increase incrementally year to year. If increases occur due to the general economy, inflation factors grow the budget in a stable manner. On the other hand, if increases occur outside that scope, base budgeting does not build in predictability. An appropriation received in a given year may not be sufficient. This is what has happened with this Catastrophic Health Care Program. From FY 2003 to FY 2007, the base general fund appropriation has risen from $8.7 million to $20.7 million. The budgeting process begins on September 1st and often it is not known what is happening until December; predictability is not there. This has raised questions about which share of the burden is being borne by the state and which share by counties.

The total program increases for FY 2002 were $25 million, and for FY 2005 they were $32.5 million. Medical inflation has caused medical procedures to exceed the $10,000 deductible cap more quickly, so a shift has occurred to the state general fund to pick up these expenses.

Another issue is the number of persons. **Ms. Holland-Smith** said that, in fact, the numbers have actually gone down from 5,498 individuals served in FY 2002 to 4,872 in FY 2005. However, medical costs have risen dramatically, reflected in that average cost per person in FY 2002 was $4,599, as compared to $6,675 in FY 2005.

Gender and residency were addressed. She said the ratio between genders was about 50/50. In looking at vehicle accidents, most people in accidents were underinsured and hit the medical cap. She also emphasized that coronary incidents were prevalent in people ages 30-50, which was surprising. The question is often asked why this Catastrophic Health Care Cost Program is not made a Medicaid program. **Ms. Holland-Smith** explained that while the federal Medicaid program does pay 70% of health care costs, many males between the ages of 18 and 65 do not qualify for Medicaid. An extended Medicaid program still might not capture individuals that Idaho might hope to include.

Another issue raised was residency (i.e. a resident of a county in Idaho, not the state of Idaho). Eligibility requirements include residency status, as well as income and asset standards.

Representative Henbest asked if DSH payments were shown as a line item on the budget. **Ms. Holland-Smith** replied that it is not shown as a specific line item, but it is a portion of the inflationary increases in Medicaid each year. **Representative Henbest** asked for a breakdown as a line item and if it would be possible to get an accounting of what DSH payments were made to what hospitals. **Ms. Holland-Smith** said that she had detailed information as to what payments go to which hospital, and she offered to give the committee a report showing historical costs and projected costs for all categories in Medicaid.

Senator Stegner asked **Ms. Holland-Smith** whether there was a significant, nonresident indigent issue. **Ms. Holland-Smith** said that in FY 2005 there was a substantial increase. The Medicaid program only pays for emergency care until the patient is stabilized if that patient does not actually qualify for Medicaid. After that point of stabilization, the county indigent program pays. The issue around residency has to do with having to pay for an individual who is not a resident and whether the payment cap should be the same as Medicaid.

Senator Stegner asked when the county cap was last changed or reviewed. **Ms. Holland-Smith** said that it had not been changed or reviewed since the inception of the program in 1991, although it has been a JFAC discussion item. **Senator Stegner** replied that he was not suggesting that the cap be raised or changed, and he asked whether she was making a formal recommendation in any way to this committee. **Ms. Holland-Smith** stated that she was simply bringing the information to the committee. **Senator Stegner** commented that he was not sure the state gets recognition for picking up the growth in the costs for indigent care that the state may well deserve. Under a more balanced or shared system, he said that perhaps there would be a periodic review of that cap and a comparison with the increased health care costs. **Ms. Holland-Smith** noted that when discussions have taken place, the counties and the administrator of the Catastrophic Health Care Cost Program have been willing partners.

Representative Henbest asked about nonresidents only being eligible for Medicaid until the patient is stabilized; she assumed that the catastrophic fund and the counties would follow the Medicaid requirements. She had also assumed that the state and the counties would address the immigration issues following the passage of the Deficit Reduction Act. She said that obviously those were not accurate assumptions and asked if there is a statutory barrier. **Ms. Holland-Smith** answered that her understanding was that there is a statutory barrier in Idaho Code limiting what counties can pay; the state Medicaid program makes payments for individuals who are **not** eligible for Medicaid (mostly due to residency issues) because they may meet the income level, but Medicaid pays for these noneligible individuals only until they are stabilized. Idaho Code does not allow the counties to put that same limit on their program.

2. Mr. Blake Hall, Catastrophic Health Care Cost Program

Mr. Hall spoke about the Catastrophic Health Care Cost Program. The same program reports are available to the committee that are provided to JFAC and the Health and Welfare Committees in the House and Senate annually. This program was organized in 1984 by the counties. The Legislature provided authorization for the counties to enter into a joint powers agreement. The counties interpreted the statute as optional and the majority of Idaho counties joined together to create this program. At that time, the counties assessed themselves $4.50 per capita to fund the program. By statute the deductible was $10,000; that deductible has been in effect since 1984. To operate this program, the Catastrophic Fund Board was created, made up of six county commissioners from each region in the state and a seventh elected at large. In 1989 Governor Batt thought one way to provide property tax relief would be to relieve counties of the cost of funding the Catastrophic Program by converting the program into a state-funded agency program. County surpluses were transferred to the state. From that date forward, the program has been administered by the Catastrophic Board, comprised of six county commissioners (one elected from each of the six state regions) and the seventh member appointed by the Governor. **Mr. Hall** said he makes it very clear every year to JFAC that the first measure in property tax relief that the Legislature is providing to the citizens of the state of Idaho is the appropriation of adequate funds for the Catastrophic Fund. Property tax relief to the counties becomes greater each year in large part due to two issues:

- (1) The deductible was established in 1984 at $10,000, when it was anticipated that there may be 40 cases coming to the Catastrophic Fund in one year. There were actually 42 and administrative costs in 1984 were $60,000 to operate the fund. The number of cases has increased to 1,100 per year and that administrative cost has increased to $190,000 annually. Operating costs have not accelerated at the same rate as claims. The counties share initially in the growth because they still pay the $10,000 deductible on new citizens moving into Idaho who are eligible. What has really occurred is medical inflation. Medical inflation outpaces all other inflation significantly.

- (2) Medical procedures are more sophisticated and as they become so, life-saving procedures become available for a greater number of patients. If the Legislature had indexed the county deductible back in 1984, it would now be somewhat in excess of

$30,000 per case, but it still remains at $10,000. **Mr. Hall** is not advocating that the Legislature increase the deductible. If that were done in one year, the county budgets would not be able to absorb that cost due to the 3% cap that the Legislature has imposed upon counties. It would also be somewhat self-defeating because the property tax relief now being provided to counties, including through the Catastrophic Fund, would be readily evaporated. **Mr. Hall** suggested that the Legislature seriously look at increasing the deductible since it is only reasonable that the state should not have to pick up 100% of the increased costs. The federal government requires a 30/70 split of the increased costs that occur in the Medicaid program. In effect, he said we are not having that kind of shared responsibility in the Catastrophic Program. JFAC has discussed increasing the deductible, but no decisions have been made. There are ways to increase the deductible, such as indexing it for the future, so as to have some shared responsibility.

Mr. Hall then talked about what can be done to help ensure that there are no gaps in legislation that would cost the state more money. According to **Mr. Hall,** every single time Medicaid is changed or reformed there is cost shifting to the counties and to the Catastrophic Fund. He suggested that if exclusions are made for Medicaid, the same exclusions need to be made for the Catastrophic Fund and the counties.

Mr. Hall next discussed illegal aliens with regard to residency versus nonresidency. The residency category on the report does not provide an indication of how many illegal aliens are being provided for, since, unlike Medicaid, there is not a question on the application regarding legal or illegal status. The counties proposed such legislation to the Legislature two years ago**.** Counties and the Catastrophic Fund pay for illegal aliens cart blanche and there have been cases that have exceeded $1 million for one single illegal alien. Illegal aliens are provided all the care needed for as long as they need it with no deductible, not just until they are stabilized. Under current law, Idaho pays for **anyone** who has been a resident of the state for 30 days. If an individual did qualify for Medicaid, Medicaid only pays for emergency care up to stabilization. This is a huge gap that is costing the state money. Modifying the statute would put the CAT Fund on a level playing field with Medicaid The state of Colorado recently passed such legislation. He suggested to the committee that not being able to ask the question whether someone is an illegal alien on the application might be an item for discussion. It has been added to the application this year, but it is optional because it is not relevant to the issue as to why they pay or do not pay.

In 1991 the county paid all of the medical bills for any individuals passing through Idaho who were injured in an accident that occurred in Idaho. There was no residency requirement at the time. Idaho then made reciprocal agreements with Washington, Oregon, Utah and Wyoming that Idaho would pay for individuals injured in Idaho from other states as long as theses states would cover an Idahoan injured in their state. The nonresidents listed in the report are from those four states.

Automobile and motorcycle accidents are significant in the Catastrophic Fund. **Mr. Hall** has suggested requiring helmets to reduce the cost to counties, but this issue would be left to the

legislators.

Mr. Hall suggested that Idaho's vehicle insurance law is antiquated. Even though there is a mandatory insurance law ($25,000 worth of liability in order to drive a vehicle), this is purely voluntary since there is no effective enforcement mechanism short of being stopped by law enforcement for another offense. He thinks the enforcement point should be upon renewing a driver's license or vehicle registration.

Mr. Hall noted that the required insurance coverage only covers the **other** person. The maximum amount of medical insurance that people have on themselves is usually only a few thousand dollars, which hardly gets them in the door of an emergency room. There needs to be an adequate law that requires a sufficient amount of insurance to cover both parties.

Mr. Hall said that initially a person was required to pay back the Catastrophic Fund in three years so as not to be deemed medically indigent and that was changed to five years. He has heard discussions about changing it to seven years. He also suggested that the committee look at whether reciprocal agreements with other states make sense any longer, including whether Idaho should be paying out-of-state providers. Currently, under a reciprocal agreement, Idaho pays for necessary medical services in another state. This becomes somewhat of a political issue but since there is a strong push toward "Buy Idaho" **Mr. Hall** suggested that perhaps if the services are available in Idaho, they might require that services be performed in Idaho. In northern Idaho, the natural referral process has often been to Spokane, and in southern Idaho many referrals are to Salt Lake. Perhaps more people need to be referred to Boise. The flip side of that, he said, is the potential problem of doing away with some levels of competition if Idaho providers know they have captured the market.

Mr. Hall commented on the millennium account. The counties only had to pay a $5,000 deductible for medical care associated with tobacco use, but **Mr. Hall** noted that this is **not** in statute. Appropriation intent language put in years ago said if services were due to tobacco-related illnesses, part of the tobacco settlement funds would be dedicated to reduce the county's deductible from $10,000 to $5,000. For the last two years, the millennium fund committee and JFAC have decided that there are better uses for those moneys and have chosen to use them elsewhere. As a result there have been no millennium fund dollars coming to the Catastrophic Fund for the last two years.

Mr. Hall ended by stating that the Catastrophic Fund has been required to seek supplemental appropriations. The fund submits a budget under the normal budgeting process on September 1. However, since their fiscal year starts July 1, the legislature is asking it to predict what bills will be received between September 1 and June 30 each year, which is almost impossible.

According to **Mr. Hall,** the biggest mistake the Catastrophic Fund ever made occurred in the years 1999 and 2000 when there was a surplus in the Fund. The Fund told JFAC in 1999 it wanted a negative supplemental and thus gave the state back $2 million, reducing the Fund's base by that amount. In 2000 there was again a surplus, so the Fund gave back $4,250,000. As a

result, the Fund's base was reduced. Subsequently, there appears to have been huge increases because the Fund is trying to increase that base. Most insurance companies have a reserve to balance unexpected expenditures in certain years and fluctuations in the economy. There is no longer any reserve in the CAT Fund and it is not attempting to build a reserve at this point. It is simply operating on a cash basis. The Fund's appropriation for last year was about $20 million; it spent about $22.75 million. It has been able to pay this since it has been very successful in getting reimbursements from individuals previously receiving services, in the amount of $2.4 million last year.

Mr. Hall stated that a study was done in 1990 by DFM about the individuals who would be eligible for the Medicaid medically needy program if the CAT Fund was eliminated. For those whom the fund served, the cost would have been greater, and less than 30% of the people would have qualified for a medically needy program.

Senator Cameron asked at what point does the county or the CAT Fund become aware of a claim. He said it was his assumption that the county does not become aware of a claim until after it has occurred. **Mr. Hall** said that the statute dictates when a county becomes aware of a claim. This could be when the individual is still in the hospital but oftentimes it is after the services have been rendered. An application is required to be filed between 31 and 180 days after the first day of service. If someone is in the hospital with a three-day stay, the county is not going to learn about that until after the services have been rendered. If someone is in the hospital for 90 days, the county is going to learn about the claim 31 days after entering. The CAT Fund does not learn about the claim until substantially later because of the uncertainty of whether the claim will exceed $10,000.

Senator Cameron asked about the list of treatments on the CAT report. Alcoholism and drug abuse do not appear on the report and are significant factors. Also a number of treatments are not necessarily one-time incidents, cancer for example or mental health treatment, which would be ongoing illnesses with ongoing costs. He asked how the CAT Fund handles these situations and whether the county and/or CAT Fund Board instigates disease management practices? **Mr. Hall** answered that the statute provides that if it is an ongoing claim, the health care providers are required to provide the counties with a management plan including ongoing services for six months. The plan comes to the county for approval, possible modification or inquiry. **Senator Cameron** asked whether the board of commissioners who are non-physicians would make the determination that the treatment plan is cost-effective or appropriate. **Mr. Hall** responded that the claims would go to a professional staff, similar to the staff at Medicaid, and if there are any issues the staff would retain a physician to assist with any concerns about a management program. **Senator Cameron** expressed interest in possibly improving that process which might help both the state and the counties. For example, a normal insurance provider would, after receiving a claim, have a discussion as to what is a reasonable payment level for that service rendered. What does the county or CAT Fund Board do regarding payment of that claim; do they discuss whether it is reasonable as per other charges in the state? **Mr. Hall** answered that counties do exactly what the state Medicaid program does; counties reimburse at the Medicaid reimbursement rate and those claims go through a Medicaid reimbursement pricing procedure.

Senator Cameron thought that one of the issues had been that there are some things that the CAT Fund Board and the counties end up paying for that Medicaid is not required to pay for, and he asked if these were not two separate messages. **Mr. Hall** answered that the Legislature has provided the counties no option except mixed messages since the CAT Fund goes through the same pricing process that Medicaid does; that is a separate issue as to eligibility. With regard to eligibility, Medicaid is only required to pay for illegal aliens or undocumented workers up to the point of stabilization and then cuts off coverage. The CAT Fund coverage does **not** cut off at that time. By statute, the CAT Fund pays for an illegal alien as though he were a citizen of the state of Idaho up through the end of necessary medical services. It is not a question of pricing, it is a question of eligibility. **Mr. Hall** suggested that this committee might recommend some modification of the eligibility issue to the legislature.

Representative Henbest asked whether the $4.50 per capita count assessment went away when the property tax relief went into effect. **Mr. Hall** said that was correct. He explained that $4.50 was what the counties were using to self-fund the program. That assessment was established due to the fact that medical bills were exceeding county budgets, causing them to have to register warrants and pay those off in subsequent years. He explained that the counties that chose to participate in the program set this $4.50 per capita that was paid for out of property taxes. When the legislature took over funding, the counties stopped putting money into the CAT Fund.

Representative Henbest clarified that in looking at the year 2005, the CAT Fund cost was $32 million with the state contributing about ½ of that amount or $16 million. She said this $16 million would make the property tax relief about $13 per capita. **Mr. Hall** said that he has never actually done the calculations. He has always left it up to the legislature to decide what the appropriate level of property tax relief should be.

Representative Henbest asked for more information regarding the assumption that Idaho spent $1 million on illegal aliens' health care claims last year. **Mr. Hall** said that while it is not ascertained whether a person is in the country legally or not, one particular case is easy to figure due to the fact that this particular person was comatose for about five years during which time Canyon county and the CAT Fund paid his medical bills. He said that case resulted in Governor Batt deciding to establish a worker's compensation for farm workers. The county does not know how many illegals are receiving care. Nonresidents receive Medicaid until they are stabilized. When Medicaid cuts off, the county and the CAT Fund pick those costs up. Regarding cases involving migrant farm workers, the statute does not require the counties or CAT Fund to cover someone who comes to the state for a temporary purpose. These cases have been challenged in court.

Representative Henbest asked for information regarding whether the county was responsible for the treatment of any of the West Nile cases, including dollar amounts. She wondered if spraying earlier would have saved money in treatment costs down the road. She said, in her opinion, this Task Force will be faced with questions regarding whether there are public health policies or disease management policies that can help relieve some of the costs to counties and the CAT Fund. **Mr. Hall** said that he was not aware of any costs to the CAT Fund for treatment

of West Nile yet and he would get that information. He suggested the Idaho Association of Counties might also have that information available. **Representative Garrett** said that a constituent wanted to know what the state is looking at for the future in regard to diseases like West Nile and prevention.

Senator Goedde stated that there are studies showing that raising auto insurance limits also raises costs, leading to more uninsured motorists. He suggested that the only way to change that would be to tighten up enforcement. **Mr. Hall** is aware of those studies. He said this would be where the issue of self-responsibility comes into play. Part of self-responsibility, in his opinion, would be to require an individual to have adequate insurance to cover himself. The amount of liability insurance currently required ($25,000) is too low and needs to be adjusted. In his opinion, Idaho is not serious about this statute and there is no serious mechanism for enforcement. He said providing proof of insurance could be part of the requirement when people renew their license plates each year.

Senator Stegner agreed that there needs to be enforcement and asked what other states are doing. **Mr. Hall** said he did not have any information on other states. **Senator Stegner** said that in terms of just costs, incarceration would seem to be an inadequate remedy for Idaho. **Mr. Hall** said he was not aware of anyone who has been incarcerated for this. There are fines levied. He said this is similar to a situation that was faced by counties with institutions of higher learning. These counties were seeing large bills due to the large number of students who did not carry insurance. The decision was made by the State Board of Education to require, as a condition of attending an Idaho college or university subsidized by taxpayer dollars, all students to have insurance. In response to a question from **Senator Goedde, Mr. Hall** explained that the State Board of Education does not have governance over community colleges. This policy has been suggested to community colleges but he does not know if it has been adopted.

3. Mr. Tony Poinelli, Idaho Association of Counties

Mr. Tony Poinelli, Idaho Association of Counties gave background information on what the county indigent directors and commissioners go through. He emphasized that the county program is an incident-based program. This means decisions are made by both the social service director and the Board of County Commissioners on a case-by-case basis. This is not an entitlement program.

Mr. Poinelli explained the process. An individual receives emergency care at a hospital. Then a determination is made as to whether there should be a county application filed or whether other resources are available. An application is filed up to 31 days after emergency services have been provided. **Mr. Poinelli** said once the county receives that application, the investigatory process begins. The social service staff at the county level has up to 45 days to do the investigation. He noted that in the past, counties have received applications with little or no information and that has improved over the years. He said some out-of-state providers still do not provide enough information. For a county to investigate, it needs to know the name, address and as much other information as possible. The application also contains releases that give the county permission

to investigate resources and so on. The social service recommendations are given to the county commissioners to either approve, deny or ask for continuance. The Board of County Commissioners has 60 days to make their decision. They have five days to mail that decision to the providers and then due process takes effect. Once the provider receives the decision, the provider or the individual may appeal.

Mr. Poinelli stated that the counties do recognize that the state has picked up a significant share of the cost. He did point out that the counties have a 3% budget cap. The other cap for counties is their levies. He said there are a few counties that are fairly close to their maximum indigent levy limit. If they reach the maximum, they have to take money from another department or agency within the county. **Mr. Poinelli** said the association is willing to discuss with the Task Force or legislature the possibility of deductible increases and other things to help both the state and the counties. He pointed out that over the years, reimbursements have been made. The counties do the collections and they are pretty hard lined. He noted that if someone makes their payments on time for a number of years, county commissioners have been known to forgive the rest of their debt.

Mr. Poinelli said that earlier speakers had covered the illegal alien issue. He did point out that, in his opinion, it would make a lot of sense to be consistent with both the state Medicaid program and the county program. If Medicaid is responsible for emergency medical care up to stabilization, the CAT program should be as well. In 1996, the county worked very hard with the Idaho Hospital Association on a recodification of the medical indigent laws and this issue was discussed at that time. **Mr. Poinelli** said that the issue deserves more attention. The providers in Idaho have come a long way since 1996 in improved technology, treatment and so on. He asked whether out-of-state providers should be paid for treatment that is readily available within the state.

Mr. Poinelli mentioned that about three years ago, the legislature directed the Association of Counties to work with the Department of Health and Welfare on a pilot program. The program looked at creating a waiver that would use some county dollars to match Medicaid dollars. This program would have been phased in over four or five years and included six pilot counties, looking at mental health care, disease management and primary care. Two years into this program, it was dropped and Medicaid reform took over. **Mr. Poinelli** emphasized that the counties, at that time, were very willing to move forward with the pilot program.

Mr. Poinelli stated that, in his opinion, the recommendations that come from the Mental Health and Substance Abuse subcommittee will be of great benefit to the state.

Representative Henbest asked whether the state reimburses out-of-state providers at the Medicaid rate. **Mr. Poinelli** said yes. He said that information from people who audit the hospitals indicates that the reimbursement is at the unadjusted Medicaid rate.

In response to a question from **Senator Kelly** regarding the point of stabilization for an undocumented patient and how the state matching the Medicaid program would work with

regard to payment for services, **Mr. Poinelli** said it was his understanding that the Medicaid program is only for emergency care. Once a patient is stabilized, counties work with the federal government to transport the patient back to a facility in their home country. He said he does not know all of the intricate details of this. **Senator Kelly** asked if the patient is not transported back to his country of origin and is a Medicaid patient, does the cost transfer to the CAT Fund. **Mr. Poinelli** said, as he understands it, that there is a limited amount of money, and once that runs out, the cost will likely fall back on the county. He said that has happened in the past. **Senator Kelly** observed that if the CAT Fund avenue were cut off, someone would have to absorb those costs. **Mr. Poinelli** agreed.

He mentioned that the application does ask if the patient is a legal resident. If they are a legal resident, it also asks for their green card number. **Mr. Poinelli** said that if that is challenged, he is not sure a person can be forced to fill that section out.

Senator Kelly stated her concern is that costs could end up being pushed back on the providers, causing them ultimately to be absorbed by patients who have the means to pay. **Mr. Poinelli** said some of those costs could fall back on the CAT Fund or the counties and there could be charity care from the providers.

Mr. Poinelli, in response to a question earlier about community colleges, said that his daughter does have insurance coverage through the community college she attends.

Representative Henbest asked for information from the counties showing a descriptive summary of those cases that the counties have paid once the Medicaid coverage has gone away.

Senator Cameron requested a graphical representation of how a claim processes through the county and the CAT Fund.

Senator Cameron stated that in his opinion, the counties do a good job with collections. He asked whether the law allows for the counties to request a costsharing or copayment from the person receiving treatment. **Mr. Poinelli** said he thinks so. He said many counties will look at the claim and determine whether it is actually better to help the individual pay a portion of the premium or their deductible. A number of counties also pay their COBRA portion. He said there is a statutory exclusion for Medicare and Medicaid deductibles or copays. **Senator Cameron** said his question was whether the law requires the person to share in the cost, not just reimburse the county. He noted that not every claim is a single incident and asked what the counties do for disease management in controlling those costs or directing treatment. **Mr. Poinelli** emphasized that the county social services directors are not social workers or physicians. There are a number of counties that have hired outside physicians and/or nurses and psychologists/psychiatrists. He said in that regard these people will send the case to a provider with whom they have contracted to see if this is the right treatment plan. He said that disease management is very difficult for county commissioners to deal with because they are not physicians. He added that welfare directors, even though they have learned about various programs and resources that are available, look at the costs more than they look at types of

treatment.

Senator Cameron said he would like clarification on how the counties are handling ongoing claims. He asked for recommendations where the statute could be changed to give the counties more flexibility or authority in collecting money. **Mr. Poinelli** said the counties would be resistant to have to go full bore to force someone to pay their bills off completely.

4. Mr. Bob Seehusen, Idaho Medical Association

Mr. Bob Seehusen, Idaho Medical Association, stated that access to care for the poor or uninsured is very limited. While hospitals provide whatever care is necessary to anyone who walks in the door, it becomes much more difficult on an outpatient basis and for any type of ongoing or preventative care.

Mr. Seehusen commented that community health centers such as the Terry Reilly Clinics do an excellent job for the poor. He said a good percentage of these health center populations is on Medicaid or Medicare and, depending on the center, 30% to 50% may be uninsured. He also noted that larger cities in Idaho are establishing free clinics that are open part-time that provide excellent services using volunteer doctors, nurse practitioners and so on. There are two family practice residencies located in Boise and Pocatello that serve a large percentage of uninsured and poor. Most of these places have a sliding scale payment system but many people are too poor to pay anything. In many cases emergency rooms are used too frequently.

He said the total cost of providing this kind of care in Idaho is unknown. **Mr. Seehusen** said that the reimbursement rate in each county is different and each claim is looked at individually and that can cause a problem. He recommended that the Task Force look at developing a more uniform policy even though counties will resist that. When payments are made on the first $10,000, physicians often receive a percentage of Medicaid. Many feel that dealing with the counties and the CAT Fund is a hassle. **Mr. Seehusen** said there are a number of barriers involved in claims and a lot of delay in getting them paid. Faced with these problems, a physician may choose not to bill for services.

Mr. Seehusen said the question is really who is paying for the care. More states are looking at some type of universal coverage, and he said that it is something that this Task Force will eventually be considering. There could be some interim steps to universal coverage. In his opinion it may be time to consider medically needy programs as the cost to the counties, the state, hospitals and practitioners, as well as those paying insurance premium increases. There are federal dollars available for these programs that should be explored. Medically needy programs help because they cover more people.

He went on to say that mental health is an area that is not being satisfactorily handled for indigents. The statute is very old and places responsibility for this care on the state, but it is very difficult to get this population into appropriate care. **Mr. Seehusen** said, in his opinion, the county should have some responsibility in paying for some of this care. He said there should not

be a difference between mental health and physical health care. He suggested making a policy that the counties follow a reimbursement program to pay for their share of indigent care.

Representative Henbest asked for clarification of the comment made that physicians get paid only a percentage of Medicaid. **Mr. Seehusen** explained that his comment relates more to reimbursement of hospitals and outpatient services. This is not a Medicaid reimbursement rate, it may be a percentage of Medicaid. He said each claim is looked at individually and each county deals with these differently. **Mr. Poinelli** said that county commissioners do have the authority in statute to negotiate lesser rates with doctors. He said, as he understands it, they are paid the Medicaid rates. These go through EDS pricing, which is Medicaid. He said this is a lesser rate than what the hospital Medicaid rate is. Also, in using EDS pricing, the various procedures done by doctors are reviewed. He has been under the impression that this rate is less than the hospital rate but it is the EDS or Medicaid rate.

Senator Cameron asked at what stage a provider becomes aware that a patient is uninsured or indigent. **Mr. Seehusen** replied that in an emergency situation, they usually do not know. On an outpatient basis, the patient goes through a screening so the provider is usually aware if the patient is uninsured or indigent. The free clinics and residencies employ doctors, so it does not make any difference for them. **Senator Cameron** asked whether the treatment plan is affected if a doctor knows a patient is indigent. **Mr. Seehusen** said it would be his hope that treatment would be the same, no matter what. He noted that if follow-up care is necessary, most physicians will try to schedule such an appointment as soon as possible after the patient is released from the hospital. This is where there is flexibility, and in some cases an indigent patient might be put off to a later date. He said the services provided should be and are the same regardless of indigency.

Senator Cameron asked if physicians know the costs of the tests or treatments they are ordering. **Mr. Seehusen** said no.

In response to a question from **Representative Garrett, Mr. Seehusen** said that in determining if a patient is indigent, the county does not pay until all of the patient's potential resources have been checked out. This can take quite a long time.

Representative Henbest said that her husband asserts that physicians cannot talk amongst themselves regarding their usual and customary charges because it could be interpreted as price fixing. **Mr. Seehusen** said it is his understanding that doctors can talk to their business partners regarding fees and what they are going to set within their own organization but not with those who are not business partners. This is part of the Sherman Antitrust Act prohibiting fee fixing. In response to another question from **Representative Henbest, Mr. Seehusen** said that physician fees are fixed by insurance companies and Medicare. Someone who does not have insurance is usually billed the full amount by the doctor or hospital while someone with insurance usually gets a price break that has been negotiated by the insurance company.

Representative Henbest said it is confusing to policymakers when usual and customary charges

vary between providers. Providers say they only get reimbursed at ten cents on the dollar, but the basis on the dollar is confusing. **Mr. Seehusen** agreed. He said that physicians that run small businesses must decide on a reasonable amount of profit to be added into the cost of care. **Senator Goedde** asked if it is common practice for physicians to set more than one fee schedule. **Mr. Seehusen** said no.

5. Ms. Karla Terry, Idaho Hospital Association

Ms. Karla Terry, Idaho Hospital Association, said hospitals are very involved in the issue of indigent care because many times that is where indigent patients first seek treatment. She said this may be due to large cases that require the hospital to expend resources and then to look for payment options. The hospital looks at other options for payment because the county indigent program is the payer of last resort. **Ms. Terry** said the hospital does get reimbursed at the Medicaid rate which will cover cost but not leave much profit.

Ms. Terry is involved with a protocol committee composed of the counties and the hospitals. One of the goals of the committee is to come to agreement on what is the proper process to get indigents approved. The goal is to establish consistency on the county side and to have consistency and cooperation on the hospital side. She said a lot of progress has been made.

Ms. Terry noted that the Association's members say that reciprocal agreements do not really work both ways. In other words, Idaho pays other states for Idaho patients but when other state's patients come to Idaho, payment is either not received or it is very small.

Representative Garrett said that from the county perspective hospitals do not make any attempt to find any other payer sources. Hospitals hand the person the indigent form on admission or as soon as possible after that. She said the county's complaint is that there has not been any adequate attempt to find out if the people are truly indigent. **Ms. Terry** said that there could be cases where that has happened but for the most part hospitals do try to attempt to find other payer sources. It is in their best interest to do this. She said the county does its own investigation, so if those other payer sources are not found early in the process, the county will eventually find them. **Representative Garrett** stated that she has also heard, from a hospital perspective, 40% to 60% of the claims to the county are denied the first time around saying these people are not indigent and should be self-pay. **Ms. Terry** said this depends on the county. Some counties have many more hoops for hospitals to jump through. The role of the protocol committee is to get together and agree on a process. She stated that most of the time everything works well.

Getting back to the issue of billing and hospital "usual and customary" charges, **Representative Henbest** stated that there is a rate that Blue Cross/Blue Shield will reimburse, a Medicaid rate and a Medicare rate for the same services. Her understanding is that there is a "usual and customary" rate for indigents. **Ms. Terry** said that hospitals have the same rate for every patient. Everyone that comes through gets billed the same. Hospitals are not precluded from evaluating cases to see if they qualify for some type of charity program. If a patient qualifies for a charity

program, many hospitals have a program, depending on how the patient's income matches with the federal poverty level, where some percentage of the bill can be written off. She noted that copayments or deductibles can also be evaluated. **Representative Henbest** has seen significant hospital bills and has also seen how her insurance carriers are able to negotiate so that she only had to pay a fraction of the actual bill. She said in some cases these amounts were stunningly significant. She emphasized that sort of thing does not happen for an indigent patient.

Representative Henbest said that when the Hospital Association or individual hospitals come to the Legislature and say they gave $6 million in charitable care each year, she is assuming this is the difference between the usual and customary charge and the amount not reimbursed. This amount includes everything that is negotiated by insurance companies, amounts not paid by indigents or the county, Medicaid or Medicare up to the "usual and customary" amount. She asked whether that was correct. **Ms. Terry** said there are guidelines that hospitals have in financial reporting for what they can report as charity. The financial guidelines say that to report a bill or charged amount as charity, there has to have been no expectation of payment. She went on to say that when they have agreements with insurance companies to accept less than billed charges, those are written off as contractual adjustments. There is also a bad debt category where payment is pursued but has not been paid. She said they also negotiated arrangements such as a prompt pay discount for uninsured or self-pay patients. **Representative Henbest** clarified that charitable means that no money at all has been paid on that bill and it has been a total write-off. **Ms. Terry** said that sometimes they can write-off a portion of that bill based upon the percentage of patient income to the federal poverty level. This would be the portion of the bill that the hospital never expected payment on. If they do not write off the entire bill, the remaining portion is pursued for payment and would show up in bad debt if not paid.

Representative Block said that the Mental Health/Substance Abuse Interim Committee has found that patients in the state mental hospitals require medical treatment and are transferred to medical hospitals. She asked whether those patients qualify for Medicaid or indigent funds. She also asked what county would be responsible if these patients do qualify for indigent funds. **Ms. Terry** said that the county of residency would be responsible.

6. Dr. James Schroeder, Idaho Primary Care Association

Mr. James Schroeder, Idaho Primary Care Association, discussed community health centers and distributed a handout containing facts about community health centers. He is the director of Family Health Services (FHS), a community health center located in Twin Falls, Idaho.

Dr. Schroeder stated that FHS advocates for patients to hospitals and other organizations to help them apply for county assistance and to negotiate better rates. He gave an example of a patient at the Jerome clinic who is a resident of Twin Falls county and had significant invasive cancer on her face that required a total reconstruction. FHS assisted her in going through Twin Falls County to get financial assistance with prior approval. The procedure was the only thing

approved and anything after that required separate application. **Dr. Schroeder** noted that FHS works with nine different counties and each one of those has a completely separate application process.

Idaho Primary Care Association is a group of ten community health centers in Idaho that represent a large number of counties and members at-large such as the residency program and free clinics. These groups are seeing the majority of indigents in the area. In 2005, the clinic had over 100,000 users. Each patient averages from three to six visits per year. The clinics offer medical, dental and mental health services. About ½ of these people are uninsured. He noted that he has seen an increase of 10% over the last fiscal year in the amount of self-pay, uninsured patients in his community. He added that of the insured people they see, most are underinsured with large deductibles.

Dr. Schroeder said that there are now 120 providers at community health centers including physicians, dentists, social workers, physician assistants and nurse practitioners. He said as a general rule most of these providers are employees at the center. It is very difficult to provide continuity of care using volunteers.

Dr. Schroeder said that an uninsured person gets different treatment. This does not mean it is a lower quality of treatment, but doctors are more cost-conscious when prescribing medication.

Dr. Schroeder went on to discuss the benefits of community health centers to the state of Idaho:

- These health centers receive $14.5 million in federal grants that help subsidize uninsured care in Idaho.
- Uninsured patients of a community health center are hospitalized less and use the emergency room less.
- Community Health Centers excel in prevention.
- Community Health Centers are adept at serving the needs of the underserved.
- Care is affordable.
- Community Health Centers are effective and cost conscious.

Dr. Schroeder explained that his center offers a sliding fee scale for services based on federal poverty guidelines. Most community health centers offer a sliding fee scale for up to 200% of the federal poverty level. At his center, if a person is at the lowest scale, the visit will cost $10.00 and any other tests involved also cost $10.00. He said while the center tries to make health care affordable, the center wants people to take part in their health care. He does not advocate everyone receiving free care because they do not tend to have as much buy-in to their care. A nominal fee makes patients feel more responsible and in control. To qualify for the sliding fee, patients have to bring in two pay stubs or their previous year's tax returns. Federal guidelines provide that for the first visit, a patient does not have to prove anything, but proof is required for the second visit.

Dr. Schroeder said that unique to community health centers is a patient majority board. His

"boss" is this community board of which the majority has to be users in the system. Another thing that makes them unique is that the centers provide a medical "home" that includes dental care and behavioral health care, which are essentials to a person's health care.

Senator Goedde said he had heard that retired physicians who want to volunteer services have no way to get affordable malpractice insurance. He asked if anyone has looked at expanding the statutes to cover that situation. **Dr. Schroeder** said this is being looked at under the federal tort claims statute. He said that the community health center has malpractice protection under this Act so it does not have to actually purchase it. This Act does not cover volunteers. This is a very hot issue at the federal level today because the Act would not cover community health center volunteers who went to help after Katrina. He thinks this will be resolved.

Senator Cameron asked how many of the patients that attend his clinic are individuals for whom he would submit a claim to the county or the CAT Fund. **Dr. Schroeder** said the clinic does not send claims to the county for any outpatient services.

Senator Cameron asked if there is any existing statute that prohibits contractual arrangements between community health centers and the county or state in taking care of ongoing treatment of patients who would qualify for indigent care. **Dr. Schroeder** said that came up last year and a safe harbor was put into place that protects entities like hospitals or agencies that develop an agreement with a community health center.

In response to a question from **Representative Block, Dr. Schroeder** said the shortage of family practice physicians is a national problem. One reason is the variation in salaries between family practice physicians and specialists. Nationwide family practice residencies are not filling. **Dr. Schroeder** said he has recruited for his clinic organization for eight years and it is getting more and more difficult. Salaries are going up significantly. He noted also that in working at a community health center, there are a lot more calls that make the job more difficult and thus less appealing to physicians.

7. Mr. Ned Parrish, Office of Performance Evaluations

Mr. Ned Parrish, Office of Performance Evaluations, reviewed the Health Care Cost Study Project Plan that was requested by the Task Force. This complete, detailed PowerPoint presentation is available at the Legislative Services Office. Mr. Parrish explained that the purpose of the study is to catalog public health care costs and to identify opportunities to redirect resources to address the needs of the uninsured. He said that $250,000 has been appropriated for the project and that JLOC and OPE will oversee the project.

OPE has received input from key stakeholders including legislators, state officials, county and school district officials, researchers from Idaho universities, representatives from the insurance industry and experts in health economics, reviewed available studies and spoken with potential consultants.

The study approach, approved by JLOC and to be completed by the 2008 legislative session, will be as follows:

- Multi-phase project
  - Phase 1 to be completed during 2007 legislative session
  - Phase 2 to be completed prior to 2008 session
- Work to be performed by consultants
- Health Care Task Force to be involved in selecting alternatives for in-depth review in Phase 2

Phase 1

- Employ consultants to provide useful information to Health Care Task Force members
  - Breakdown of health care spending in Idaho
  - Size and composition of Idaho's uninsured population
  - Options to expand insurance coverage and/or services for the uninsured
  - Analysis of factors that drive health care costs
- Completion targeted for February 2007

Phase 2 will involve:

- Holding facilitated discussions with Task Force members to select options for further study
- Conducting in-depth review of selected alternatives to assess their impact on:
  - Health care costs
  - Coverage rates
  - Health care services for the uninsured

Mr. Parrish said the next steps after today's meeting include developing a detailed scope of the work for Phase 1, obtaining JLOC approval of the final scope, completing an RFP and sending it to potential consultants and contracting with multiple teams of consultants.

Representative Block asked whether OPE planned to include long-term care insurance in the study. **Mr. Parrish** said OPE is trying to refine what will be included. He said the definition of health care is very broad and the definition used must be such that data will be available.

Representative Garrett commented on the need to be aware that mental health is entwined with overall health. **Mr. Parrish** said most definitions include mental health.

8. Mr. Laren Walker, AmeriBen/IEC Group

Representative Deal introduced **Mr. Laren Walker,** to give an update on the high risk reinsurance pool. **Mr. Walker** distributed a balance sheet of the high risk pool for June 30, 2005 and 2006. This information is available in the Legislative Services Office and also from the

Department of Insurance and shows $11,243,516 deferred state tax funds that have not been used by the program and that have come from the premium tax dollars.

His handout also included an income statement of the program for the first half of 2006. Premium dollars accrue at about $200,000 a month. **Mr. Walker** explained that this is the first component of revenue to the high risk pool. The second component is the premium tax dollars, and the third, if need be, is an assessment to the carriers. He noted that this third component has not been necessary. The revenues in this statement only come from the carriers with the investment gains and losses.

Mr. Walker said that expenditures, as would be expected, are the largest component. These are the claims incurred by the program. Year to date there have been $2.3 million in claims.

His handout shows that there have been 1,440 lives in the high risk pool through July 20, 2006, and provides a breakdown of ceded lives in the high risk pool by carriers. It also contains a graph showing activity by plan type (Basic, Standard, Cat A, Cat B and HSA). The Cat B product is growing the fastest. He noted that the HSA product was just introduced in 2006 and it is also beginning to take off. **Mr. Walker** added that the number of lives enrolled in the pool seems to stay right around 1,440.

A large claims paid report was included in his handout, for any claims over $50,000. **Mr. Walker** said that by nature of being a high risk pool, it has high risk individuals that are likely to have expensive claims. It is just a matter of time before there is a million dollar claim. The reserves that were recommended for this program are about $19 million, given the makeup of this group of high risk individuals.

Senator Goedde asked why the incurred but not reported (IBNR) amount went down from 2005 to 2006. **Mr. Walker** said that the IBNR is established every year based on an actuarial study. This number does not look very far into the future as far as potential liability. **Senator Goedde** clarified that the IBNR looks at actual claims activity rather than a guess as to what those might be. **Mr. Walker** said that is correct. He said the actuarial committee will look at those numbers and apply a factor that looks at trends and loss ratios.

Senator Cameron asked what the status is for Idaho obtaining federal assistance and funding for its high risk pool. **Mr. Walker** said they have requested federal funds three times with the last request being completed in August. He said in prior years, the request was rejected due to plan design issues. Since that time, changes have been made, and there have been indications that everything is in place for Idaho's plan to receive some federal dollars.

9. Ms. Patti Campbell, Department of Health and Welfare

Ms. Patti Campbell, Department of Health and Welfare, gave an update of the CHIP Plan B and the Access Card. She distributed a handout with more detailed information on these plans that is available at the Legislative Services Office. The following changes made to these

programs since last year include:

- No asset test for children - effective April 2006.
- Poverty levels increased to 2006 limit - March 2006.
- CHIP-B benefit package changed to match Basic Plan benefits - July 2006.

Planned changes include:

- Remove requirement that employers pay 50% of spouse's premium for Access to Health Insurance.
  - SB1417 passed in 2006 legislative session.
  - HIFA waiver amendment submitted to CMS; questions received, but approval is still pending.
- Premiums for individuals 133-150% of federal poverty level (FPL) who are on direct coverage.
  - HB776 and HCR50 passed in 2006 legislative session.
  - Implement Fall 2006.
- Preventative Health Assistance for individuals responsible to pay premiums.
  - HB663 passed in 2006 legislative session.
  - Planned implementation Fall 2006.
- Remove uninsured requirement for individuals who choose to participate in premium assistance.
  - Federal waiver needed with cost neutrality established.
- Allow all individuals to choose premium assistance (currently only those over 150% of FPL can choose).
  - SB1417 passed in 2006 legislative session.
  - Federal waiver needed; CMS requiring us to provide wraparound coverage to grant waiver.

The handout shows the number of eligible children as of July 2006 for Direct Medicaid Coverage for individuals 150-185% of FPL at 2,026. The number of applicants from July 1, 2005 to June 30, 2006, was 4,807. For the Access Card the number eligible is 88 with 162 applicants. The biggest reason people are turned down is due to a failure to clarify information. Premiums collected year-to-date equal $257,495, with average monthly expenditures of $132 for CHIP B and $78 for the Access Card.

Ms. Campbell said that 75 employers are participating in the premium assistance for employees of small businesses and that 17 employers chose not to renew the insurance. There are 332 participating individuals. Seven hundred ninety-two have been denied. The biggest reason for denial was too high of income.

Representative Henbest asked whether wraparound service means that individuals will get benefits from their insurance package and small pieces will be covered by Medicaid. **Ms. Campbell** said that was correct and that it is very complex.

Senator Cameron asked for information showing how many premium tax dollars are available that are not being utilized by the programs and how many lives that would affect. **Ms. Campbell** said there was $3.3 million as of July 1 for children and about $1 million for adults. She said she would provide this information in writing for the Task Force. **Senator Cameron** asked whether that $3.3 million has been utilized or budgeted. He noted that this does not include the federal match of about $9 million on an 80/20 basis. **Ms. Campbell** said she would get that information.

Senator Cameron asked, regarding the 17 employers that chose not to renew coverage, whether there is any type of exit survey done when they leave the program. **Ms. Campbell** said no exit interviews were done on these 17. She said these are all very recent. **Senator Cameron** said it would be important for the Task Force to know why people are leaving. She said they could do some follow-up on this.

10. Mr. Tom Donovan, Deputy Attorney General for the Department of Insurance

Mr. Tom Donovan, Deputy Attorney General for the Department of Insurance, spoke on behalf of Acting Director Shad Priest regarding draft rules for the coverage of newborns and newly adopted children. A copy of this draft is available in the Legislative Services Office.

Mr. Donovan explained that this rule is in the drafting stage. For background, he said that HB644 was proposed last year dealing with cleft palate coverage. At some point the decision was made that the Department would engage in rulemaking in light of congenital anomalies coverage for newborn children that already exists in several statutes. A negotiated rulemaking meeting notice was published and held on June 29, 2006, with a number of interested parties participating. The Department received comments from a number of persons including the Idaho Association of Health Plans on behalf of about five insurance carriers.

A copy of this draft has been sent out to anyone who expressed interest, and additional feedback and comments have been solicited by the Department of Insurance by September 15, 2006.

Mr. Donovan said the rule is designed to further elaborate on what the statutes provide. In general the statutes provide that health plans provide coverage for accident and sickness for newborn children. This rule proposes that health plans should also do so for congenital anomalies so long as a newborn is enrolled within 60 days. One of the more critical areas is the definition of "congenital anomaly." Some of the comments urged the Department to limit the term to the function of one's body. The draft definition includes that a congenital anomaly means a "condition existing at or from birth that is a significant deviation from a common form or function of the body." The draft contains explanatory information on the Department's thinking and provides feedback on the comments received.

Representative Henbest asked, since this is just a draft rule, will it be before the Legislature for this upcoming session. **Mr. Donovan** said he believes so. His understanding is that the Department plans to push this forward as a proposed rule for the next legislative session. He

thinks the goal is for it to be proposed and become a final rule in 2007.

11. Senator Joe Stegner

Senator Stegner gave an update of the Mental Health and Substance Abuse Interim Committee. He said the committee met at the Idaho State School and Hospital in Nampa in June and at State Hospital South in Blackfoot. The committee will meet next week at State Hospital North in Orofino. The committee does not have any recommendations at this time. It has been taking considerable testimony on whether there needs to be organizational changes in the areas of substance abuse and mental health. **Senator Stegner** noted that the Governor has actually done that by creating a Division of Behavioral Health within the Department of Health and Welfare. The new division chief is Kathleen Allen. He said the committee is trying to understand how that organizational change will be implemented. The committee is not ruling out the consideration of a recommendation for the creation of an entirely new
Department of Behavioral Health. There has also been the creation of a drug czar in the Governor's Office.

Senator Stegner said meeting at the various state schools and hospitals has been very helpful as the committee tries to understand its role within the substance abuse and mental health system in Idaho. The committee plans to hear a report from the Transitional Working Group in November. Input has been taken from the Idaho Federation of Families for Children's Mental Health, Association of Counties, the National Alliance on Mental Illness (NAMI), the Idaho Division of Vocational Rehabilitation and District Court Judges dealing with the implementation of drug courts and mental health courts. He said the committee has accumulated recommendations but has not held any formal discussions on them.

12. Mr. Paul Leary, Department of Health and Welfare

An update on Medicaid Reform was provided by **Mr. Paul Leary, Department of Health and Welfare**. His complete PowerPoint presentation is available at the Legislative Services Office. **Mr. Leary's** presentation was limited to the implementation status of the Medicaid Reform. He said the Department received federal approval to move forward with the Medicaid/Medicare modernization and is moving forward in phases. The first phase is to get the building blocks in place and then to get the state plan updated. This includes the benchmark benefit package, the basic package and the enhanced benefit package.

Mr. Leary said a new Medicaid application process has been implemented. This involves working with the Division of Welfare to have a family Medicaid consolidated unit. A health questionnaire has been incorporated into that application process since the modernization is moving toward looking at health needs, not just income requirements.

The expedited Health Connection assignment is also a process that is implemented through the family Medicaid unit and includes Medicaid and self-reliant individuals. This process allows individuals to hook up with a primary care physician early in the eligibility process to look at

wellness and prevention. This is very important.

Plan assignments are now based on health needs. As the transition begins into the Medicaid modernization, any new applicants or Medicaid recipients that are up for renewal will have their health needs evaluated and will be placed in either the basic plan or the enhanced plan. **Mr. Leary** explained that the enhanced plan has robust mental health benefits.

Mr. Leary discussed Phase 2, which includes personal health incentives and rewards. Phase 2 allows the Department to reward individuals who want to change their health habits. He said this program, as well as the premium payments for good choices, offers incentives for healthy habits.

Implementation status details include:

- **Prevention & Wellness:**
  - Well child exam reimbursement.
  - Adult routine annual health exam coverage.
  - Healthy Schools initiative.

(**Mr. Leary** said that physicians and physician groups have told him that taking the well child exam reimbursement to the level of commercial carriers was one of the best things done in this reform.)

- **Good Health Decisions:**
  - Cost-sharing (Fall).
  - Preventive Health Assistance for smoking cessation & weight loss (Fall).
  - Premium Payment Assistance for up-to-date well child check-ups (Fall).
- **Strengthen employer-based health insurance:**
  - Remove financial specification for spousal payment (pending federal approval).
- **Managing their own lives:**
  - Consumer direction (Self Determination) (Fall).
  - Collaborate on family-directed care (research phase).
- **Opportunities for employment:**
  - Medicaid Buy-In (January).
- **Savings & Efficiencies:**
  - Best price negotiated for incontinence supplies.
  - Multi-state purchasing pool for pharmacy pricing.
  - Pay for Performance Pilot: diabetes.
  - Medicare enrollment as a condition of Medicaid eligibility.
  - Transportation brokerage (January).
  - Dental plan outsourcing (RFP – September).
- **Coordination with Medicare:**
  - Integrate benefits/administration with Medicare Plans (January).
- **Nonpublic financing options for Long-Term Care:**
  - Aging Connections Pilot (October).

- Long-Term Care Partnership Program (November).
- LTC financing reforms (asset transfers & look-back).
- LTC financing reforms (estate recovery).

Mr. Leary said that unresolved policy and program issues include caregiver support benefits, premium assistance expansion, targeted copayments and the Deficit Reduction Act regarding home and community-based services.

Implementation challenges include:

- Major computer system reprocurement.
- Integrity of mental health assessment process.
- Administration of new prevention services.
- Enrollees who don't pay premiums.
- New federal citizenship requirements.

Representative Garrett asked about the integrity of the mental health assessments. **Mr. Leary** said there are multiple issues involved. He noted that there is probably not enough information on what the process is and how it is done. He said when the Department did put out an information release about the process, it was inundated with assessments of people that were not transitioning at all. Communication needs to be improved. He said in looking at transition, there were a couple of individuals who were put in the basic plan who thought they should have been in the enhanced plan. An assessment will be done for these individuals. **Representative Henbest** said, regarding integrity, this was similar to the issue of the person doing the assessment who also is providing the service. She said there was interest in disconnecting the two so that the assessor was not the recipient of the dollars for service. **Mr. Leary** said that was correct and that there will be a presentation made during the next legislative session on a pilot project that does this.

Senator Cameron said he would be interested in seeing each of the issues in spreadsheet format showing who made the decision to proceed or not and what the status is. He said he is concerned that the Legislature should be involved in some of the decision making processes. **Mr. Leary** said there is information put together showing legislation from the last session and what they are moving forward with. He said he would get the other information as well.

In response to another question from **Representative Garrett, Mr. Leary** said that the Department is looking to pilot the mental health side in a small area in order to get their hands around it, learn from what is implemented and move forward accordingly. He said there is no reason to do a pilot project unless something is learned from it.

B. Other Business

Representative Deal referred to a letter that was sent to **Senator Cameron** from the Department of Insurance. This was an update on the Multiple Employer Welfare Arrangement (MEWA)

legislation from the last session (HB822 and HB825). He explained that after July 1, 2006, there was a 90 day period for these self-funded multiple employer health plans to register with the Department of Insurance. This letter says that two plans have done this: the Snake River Sugar Company and the Timber Products Manufacturers Trust. The Department has been contacted by four other plans and two of the four have submitted applications, neither of which is complete.

The meeting was adjourned at 3:10 p.m.