MINUTES

(Subject to Approval by the Task Force)

HEALTH CARE TASK FORCE
November 22, 2010
Boise, Idaho

Health Care Task Force members present were Senators Dean Cameron, Joe Stegner, Patti Anne Lodge, Tim Corder, John McGee, and Nicole LeFavour; Representatives Gary Collins, Carlos Bilbao, Jim Marriott and Fred Wood. Representatives Sharon Block, Elaine Smith and John Rusche were absent and excused. Legislative Services Office staff present were Paige Alan Parker, Amy Johnson and Eric Milstead.

Others attendees were: Representative Phylis King, District 18; Representative Sue Chew, District 17; Susie Pouliot and Ken McClure, Idaho Medical Association (IMA); Steve Millard and Toni Lawson, Idaho Hospital Association; Heidi Low, American Cancer Society; Marilyn Sword, the Developmental Disabilities Council; Skip Oppenheimer and Marsha Bracke, Governor's Behavioral Health Transformation Work Group; Richard Rainey, M.D., Idaho Immunization Assessment Board; Bruce Krosch and Richard Roberge, Southwest District Public Health Department; Kurt Stembridge, GlaxoSmithKline; Jeff A. Buel, Johnson & Johnson; Julie Taylor and Steve Tobiason, Blue Cross of Idaho; Benjamin Davenport, Risch Pisca, PLLC; Kathie Garrett, Idaho Council on Suicide Prevention; Larry Benton, Benton, Ellis & Associates; Director Richard Armstrong, Leslie Clement, Dick Schultz, Jane Smith, Christine Hahn, M.D., Cynthia Yock and Elke Shaw-Tulloch, Department of Health and Welfare (DHW); Tim Olson, Regence BlueShield of Idaho; Teri Barker, Denise Chuckovich, Jesus Blanco and John Watts, Idaho Primary Care Association (IPCA); Bill Roden and Sarah Fuhriman, Roden Law Office; Jean Deluca, Delta Dental, Idaho; Scott Ki, Boise State Public Radio; Director Bill Deal, Shad Priest and Eileen Mundorff, Department of Insurance; Jim Genetti, Idaho Association of Health Underwriters (IAHU); Steve Thomas, Idaho Association of Health Plans (IAHP); Joie McGarvin, American's Health Insurance Plans; Corey Surber, Saint Alphonsus; Roger Simmons, Idaho Dental Hygienist's Association; Chris Tilden, the Mountain States Group; Elizabeth Criner, Veritas Advisors, LLP, representing MWI Veterinary Supply, Inc.; McKinsey Miller, the Gallatin Group; Angela Richards, Intermountain Hospital and Willamette Dental; Norm Varin, PacificSource; Ryan Mitchell; Rob Mitchell; Nancy Mitchell; Nels Mitchell; Bob Uebelher; Pro-Life; Brad Iverson-Long, Idaho Reporter.com; Jim Bauer, DRI; Richard Popper, Director of Insurance Programs, HHS Office of Consumer Information and Insurance Oversight (by conference call); and Joy Wilson, National Conference of State Legislatures (by conference call).

The meeting was called to order by **Co-chair Senator Cameron** at 9:07 a.m. Guests were welcomed and a silent roll call of task force members was taken.

Skip Oppenheimer, the chairman of the Governor's Behavioral Health Transformation Work Group (BHTWG) gave a PowerPoint presentation titled, "A Plan for the Transformation of Idaho's Behavioral Health System." This PowerPoint presentation may be viewed at:

www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1122_oppenheimer.pdf . **Mr. Oppenheimer** recognized the efforts of the work group members and advisors who were present, including Department of Health and Welfare Director **Richard Armstrong**, Senator **Joe Stegner**, Representative **Sharon Block**, former Representatives **Kathie Garrett** and **Margaret Henbest**, Southwest Public Health District Director **Bruce Krosch**, and **Amy Johnson**, Budget and Policy Analyst for the Legislative Services Office.

Mr. Oppenheimer explained that the work group was created in 2009 by Executive Order 2009-04 and was extended this year by Executive Order 2010-01. The efforts of the work group built on the prior efforts of others and kept in mind the large number of people who need behavioral health services. A panel of experts, some from other states, was put together to assist the work group. Input was received from stakeholders, including some 400 in an effort to reach out to the stakeholders. Two BHTWG generated documents were distributed to task force members: "A Plan for the Transformation of Idaho's Behavioral Health System," dated October 28, 2010, and "Response to Public Comment Organized by Theme," dated October 29, 2010. These documents are available for review in the Legislative Services Office. The plan was adopted by the work group with 100% support.

The plan that was adopted proposed: the integration of Idaho's mental and substance use disorder systems, the empowerment of regions to lead capacity building for their areas, the providing of an array of core services in each region utilizing a phased-in approach and an increased privatization of service delivery. This integrated system envisions increased accountability system-wide, the capturing and reduction of costs, the generation of outcome-based results, the application of consistent statewide standards, the generation of effective and collective data gathering and sharing and the production of an intentionally coordinated and measurably efficient system. A braided funding system is anticipated.

According to **Mr. Oppenheimer**, the structure of the behavioral health system would include Regional Behavioral Health Community Development Boards. These boards would replace the current Regional Advisory Councils (RACs) and the Regional Mental Health Boards (RHMBs). State level coordination would be provided through the newly created Idaho Behavioral Health Planning Council, replacing the current Idaho State Planning Council on Mental Health and the Interagency Committee on Substance Abuse and Treatment Prevention, and a Behavioral Health Interagency Cooperative, replacing the fragmented direction provided by the Department of Health and Welfare, the Idaho Department of Juvenile Corrections, the Idaho Department of Correction, the State Department of Education, the Office of Drug Policy, the courts and the counties. A Director of Transformation would direct the Behavioral Health Interagency Cooperative. The Department of Health and Welfare would serve as the State Behavioral Health Authority, providing quality assurance through the evaluation and monitoring of standards and outcomes.

An array of core services will be phased in at the regional level to provide a "floor" of services available to consumers and families at as local a level as possible. Contracts will be developed with provider groups that reflect statewide standards, quality measures and consistent fees for the same services purchased by the regions, with agencies paying on behalf of their clients. The

emphasis will be on prevention and intervention and will include inpatient hospitalization and assertive community treatment services that respond to crisis situations.

Hopefully, the Governor will sign an executive order in the near future creating the Planning Council and the Interagency Cooperative. Legislation will be required in 2011 to eliminate the RACs and RHMBs, create the Planning Council, integrate substance use disorder, suicide and mental health into the Planning Council's responsibility and establish the Director of Transformation to direct the Interagency Cooperative. Funding may be acquired by transferring moneys from the Office of Drug Policy to the Interagency Cooperative by cooperation between agencies to develop a braided funding environment utilizing existing funds and by a committed effort at the regional and state level to pursue grant funding.

Senator Stegner thanked **Mr. Oppenheimer** for this leadership and for the diligent and committed work of the BHTWG. **Senator Stegner** commented that the proposed behavioral health service delivery structure will give regional authorities the ability to provide local services that match local needs.

Representative Marriott asked about the experiences of other states in recruiting volunteers to assist in the delivery of behavioral health services. **Mr. Oppenheimer** replied that volunteers can help in providing transportation, employment opportunities, temporary housing and, with proper oversight and training, the management of medications. However, **Mr. Oppenheimer** warned that utilizing volunteer services is not a panacea.

Representative Wood asked about the adequacy of the Department of Health and Welfare role in auditing and overseeing the privately delivered services under the BHTWG's proposal. He commented that without adequate oversight, the fee-for-service model is doomed from the start due to cost concerns. **Mr. Oppenheimer** replied that this issue formed a fundamental part of the BHTWG's discussions. The BHTWG envisions the Interagency Cooperative and its Director as the transformation vehicle, but the Department of Health and Welfare is not going to turn over the service delivery to the regions and their contracted providers until the behavioral health system infrastructure and its capacity to deliver services are in place. **Representative Wood** stated that he believes this proposal is on the right track.

Former **Representative Henbest** augmented the response to **Representative Wood's** concern by stating that the only way behavioral health can be managed is through contracted, capitated services. The regions will have a voice in the contracts with the service providers, but the Department of Health and Welfare will have oversight over these contracts.

Senator Cameron closed the discussion by noting his understanding that the BHTWG's proposal is a work in progress, especially as to funding.

Former Representative **Kathie Garrett**, the chair of the Idaho Council on Suicide Prevention, addressed the task force on suicide prevention in Idaho. Her presentation, "Idaho Council on Suicide Prevention Crisis Hotline" as well as these handouts: "Suicide in Idaho: Fact Sheet, July 2010"; "Crisis Hotlines: A Reliable Safety Net in a Challenging Budget Environment"; "Idaho Suicide Prevention Hotline: Analysis of Options for Decision Making" may be viewed at the

Legislative Services Office. Additional information can be accessed at: www.suicidepreventionlifeline.org.

Ms. Garrett related that the Idaho Council on Suicide Prevention was created by Executive Order in 2006 and was renewed in 2010. Top experts on suicide prevention serve on the Council as well as **Senator Goedde** and **Representative Block**. The Council received minimal financial support.

Relevant statistics on suicide in Idaho include a 22% increase in Idaho suicides from 2008 to 2009 and a 40% increase from 2007 to 2009. Three hundred and seven people committed suicide in Idaho in 2009, with 77% being men. Idaho has the eleventh highest suicide rate in the nation, especially individuals with mental health and substance use disorders who have shortened lives due to suicide.

Prevention activities include working in partnership with other groups including the Idaho Hospital Association on best practices in the emergency room context, the Department of Education on suicide prevention activities in the public schools and in efforts to establish a crisis hotline. In 2009, Idaho lost its funding for a crisis hotline. Currently, Oregon provides crisis hotline services for Idaho. Crisis hotlines reduce suicides by providing intervention and helping to develop a safety plan.

Idaho State University was commissioned to undertake a study to determine how a crisis hotline can be reestablished and maintained in Idaho. According to a survey of crisis hotlines in other states, ISU reported that 78% of crisis hotlines are operated by nonprofit organizations. Most have a combination of paid and volunteer staff. Funding is generally through dedicated public funds. The estimated cost for a crisis hotline in Idaho is between $100,000 and $250,000 per year. The Council is currently seeking to recruit an organization to run a crisis hotline in Idaho but has been unable to find such an organization with the ability and funding to do so.

Senator LeFavour asked if there were other suicide prevention services that approached a crisis hotline in importance. **Ms. Garrett** answered that working with primary care providers who often see depressed individuals on the verge of suicide and help them recognize the potential for suicide. However, there is currently no state agency that is taking the lead on suicide prevention.

Department of Insurance Director **Bill Deal** gave a PowerPoint presentation to the task force on "Developing an Insurance Exchange in Idaho." This PowerPoint presentation can be viewed at: www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1122_deal.pdf

Director Deal informed the task force that on October 6, 2010, he and Deputy Director **Shad Priest** visited Utah to see the operation of its insurance exchange created before the passage of the federal Patient Protection and Affordability Care Act of 2010 (PPACA). The Utah exchange was created in 2008 through legislation and has had several legislative augmentations. The vision for the Utah exchange was to develop a consumer-driven health care and insurance market that provides greater choice, expanded access, individual responsibility, higher quality and improved health. The Utah exchange is voluntary and features private sector vendors, marketing and outreach through the Chamber of Commerce and professional and trade associations and the education of brokers, consultants and human resource managers. Key to the Utah exchange is an

aggregator that permits employers to determine how much they want to contribute to an employee's health insurance and then permits employees to determine the policy they desire through the additional premium they are willing to contribute. The advantage to employers is simplified benefits management, predictable costs, expanded coverage choices and the preservation of tax benefits. The advantage for employees is individual control and choice, payment with pretax dollars, plan portability and premium aggregation.

Utah is trying to get its exchange accredited under the PPACA. However, the Utah exchange does not, as yet, have a Medicaid piece.

Representative Bilbao asked whether individual plans will be included in the exchanges required under the PPACA. **Director De**al replied that individual plans will be outside the exchanges unless a subsidy is involved.

Representative Wood asked **Director Deal** to compare the Massachusetts exchange, which has been granted grandfather status under the PPACA, and Utah exchange, which has not. **Director Deal** explained that everyone is enrolled in Massachusetts while the Utah exchange is voluntary and limited to small group plans. Massachusetts served as the model for the PPACA. **Representative Wo**od asked if the defined contribution aspect of the Utah exchange, which allows employees to shop around for the best coverage, is available in Massachusetts. **Director Deal** replied that he was not aware of such availability in Massachusetts.

Senator Stegner asked whether the Utah exchange is still in the preliminary implementation phase. **Director Deal** described the Utah exchange as "fledgling" with only around 200 companies enrolled. There is still a question of whether the exchange's contractor can take care of the exchange's services. **Senator Stegner** commented that while Massachusetts doesn't know how it is going to pay for its mandatory health insurance program, 97% of its citizens have signed up for health insurance.

Director Deal continued his presentation on planning for an exchange in Idaho. Idaho goals include keeping health insurance companies in Idaho viable and keeping the agents and producers involved. The Idaho exchange must be up and running in 2014. Four phases are planned: (1) exchange design, including governance, administration, product development and public outreach; (2) selection and coordination with carriers, including the development of an administrative process and an enrollment process; (3) initial implementation with actuarial evaluations and communication of the pool structure and eligibility requirement to the public; and (4) implementation completion with the finalization of web integration with the carriers and transition of the High Risk Pool members to the exchange. The Department of Insurance is working closely with the Department of Health and Welfare on this project. A one million dollar planning grant has been received from the federal Department of Health and Human Services (HHS). The Department of Insurance does not expect to submit legislation on exchanges until the 2012 session.

Senator Goedde asked what the consequences might be if the PPACA was repealed in 2012. **Director Deal** stated that he is concerned by that possibility. The Department currently has a trail to follow from HHS. The possibility that a repeal might occur is one reason for holding back on

the submission of legislation until 2012. He acknowledged that with the election of so many Republican governors this year, there could be a different direction.

Senator LeFavour expressed her disappointment that the Department's emphasis appears to be on insurance companies and providers rather than on individual citizens who are going bankrupt due to the high cost of health care and who lack access to preventive care.

Richard Rainey, M.D., the Idaho Medical Director for Regence BlueShield of Idaho and the Chairman of the Idaho Immunization Assessment Board, addressed the task force on the status of that Assessment Board that was created by HB 432 (2010). A handout provided by **Dr. Rainey**, titled "Idaho Childhood Immunization Policy Commission: Report to the Health Care Taskforce," is available in the Legislative Services Office.

Dr. Rainey provided a brief history of the circumstances that led to the establishment of the Immunization Assessment Board. With the 2009 fiscal year budget cuts, the Department of Health and Welfare was no longer able to provide vaccine for insured children, along with the vaccine provided for uninsured children under the federal Vaccine for Children (VFC) program. Although temporary funding was able to continue those vaccines until January of 2010, the Legislature responded to the problem by creating the Immunization Assessment Board, which assesses insurance companies that have insured lives in Idaho and provides the moneys to the Department of Health and Welfare so that it can purchase vaccines for insured children at the Centers for Disease Control (CDC) reduced price. This process allows carriers to provide vaccines to insured children at the CDC price and allows providers to stock vaccines for all children together, rather than segregating vaccines for insured children separately from other children. According to **Dr. Rainey**, the PPACA requires insurance companies to cover specified vaccines.

Dr. Rainey described the Assessment Board as representing the key stakeholders, including the insurance carriers, business groups, physicians and government agencies. One problem with the legislation that created the Assessment Board is that it allows the Board to contract with an administrator, but did not give the Board authority to pay such an administer. The Department of Insurance has stepped in to address this problem.

Vaccine cost for insured children is eight million dollars for the current fiscal year. This provides funding for all vaccines provided under VFC, except for HPV. To determine the amount of the assessment, the Department of Insurance sent out surveys to all health insurance carriers it could identify to determine the number of insured children lives each such carrier had in Idaho. The Department of Health and Welfare provided information on the cost of the covered vaccines. The Assessment Board then calculated the total cost and prorated the cost to the individual insurance carriers. For fiscal year 2010, that came out to be $47 per insured child. The Idaho insurance carriers have paid their assessments. The out-of-state carriers have been more of a challenge, but most of the identified carriers have paid. If the Assessment Board is unable to collect from the out-of-state carriers, then the ability of the Board to function will be compromised. The Assessment Board is investigating when it can fund the HPV vaccine.

The Assessment Board's legislative needs were addressed by **Dr. Rainey**. First, it needs the authority to pay an administrator. Second, it needs legislation clarifying its ability to consult with the Department of Health and Welfare and other experts. Both of these issues are noncontroversial. More controversial is a mechanism to clarify how new vaccines will be added to the list of vaccines for which assessment will be made. The task force's co-chairs have convened a stakeholder's group to work on a legislative proposal, which is in the drafting process. **Senator Cameron** told **Dr. Rainey** that the task force is looking forward to working with the Assessment Board on future reports.

Ryan Mitchell of Pocatello, Idaho, was invited to address the task force regarding an unfortunate incident last September when he was shot in the back by a mentally disabled stranger who was no longer on his medication because of state budget cuts that negatively impacted the Assertive Community Treatment (ACT) program operated by the Department of Health and Welfare. **Mr. Mitchell's** presentation consisted of a letter addressed to the task force, a copy of which is available at: www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1122_mitchell.pdf . At the close of his presentation, **Mr. Mitchell** asked the task force to consider four questions: (1) How are we, as a state going to make sure this incident will not happen again; (2) Why wasn't the family of the perpetrator notified of the medication cuts; (3)Why did the Legislature cut this program when it was warned that an incident like this might happen; and (4) Isn't it the responsibility of our government to help those who are not able to take care of themselves and, more importantly, to ensure the public safety?

Senator Cameron thanked **Mr. Mitchell** for his courage and informed **Mr. Mitchell** that he co-chairs the Joint Finance and Appropriations Committee and is aware that budget cuts have consequences. Health and Welfare Director **Richard Armstrong** was asked to address the issues raised by **Mr. Mitchell**.

Director Armstrong stated that the Mitchell incident illustrates the frightening aspect of decision making. Due to budget cuts, seven staff positions were cut or not filled in Pocatello. Two hundred and six individuals affected by the ACT program cutbacks were identified. If the individual had insurance coverage for mental health services, that individual was cut from the program. However, under a fee-for-service system, the individual has to present himself to the provider, whereas under the ACT program, the Department goes to the individual. The individual in question appeared to be stable and able to seek out the services, but one never can tell what is going on inside the individual. The Department is going to take another look at the program and the identified individual, even though this will result in a budget overrun of five million dollars.

Senator Cameron expressed his opinion that the Department will do whatever it can to prevent such an incident in the future. He asked whether the individual in question had insurance coverage. **Director Armstrong** answered that coverage was available. **Senator Cameron** asked what efforts were made to provide notice to the individual and his family. **Director Armstrong** replied that under the federal Health Insurance Portability and Accountability Act, permission is required to provide notification to the family of individuals with mental health problems.

Senator LeFavour asked whether individuals in the ACT program are all challenged. **Director Armstrong** responded that two thirds of the cases are not in crisis but involve the management of

medicine. In the past, care was provided by the Department even if the individual had private insurance coverage, since the individuals were often more comfortable with the Department's caseworker. Now, the Department uses assessments to determine need, but this is still a subjective call.

Director Armstrong next addressed the impact of PPACA on Idaho's Medicaid program. A copy of his PowerPoint presentation on this subject may be viewed at: www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1122_armstrong_reform.pdf. Handouts were also provided by **Director Armstrong** titled "Medicaid Mandatory Benefit Analysis," available at: www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1122_medicaid_handout.pdf, and "Approaches to Cost Containment in State Medicaid Programs," available at: www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1122_medicaid2_handout.pdf .

According to **Director Armstrong**, there are actually two pieces of federal legislation that are controlling: the PPACA and the Health Care and Education Affordability Reconciliation Act of 2010. Specific Medicaid provisions are required by specified dates. For 2010, required are: coverage for freestanding birth center services; coverage for smoking cessation for pregnant women (without cost sharing); concurrent care for children in hospice; decrease in Medicaid drug rebates to states due to retention of the rebate moneys by the federal government to help pay for health care reform, resulting in a three million dollar loss to Idaho; extension through fiscal year 2016 of the "Money Follows the Person Rebalancing Demonstrations;" implementation of fraud, waste and abuse programs; and extension of state repayment of the federal share of Medicaid overpayment from the current 60 days to one year.

Required in 2011 is the prohibition of payments to states for conditions that arose in the facility providing service. The Department is still awaiting guidance on this new federal requirement. Required in 2013 are: coverage of preventive services and approved vaccines, with an increase in the federal share of FMAP of one percent with no cost sharing; increase in payment for primary care doctors with 100% federal funding through December 31, 2014; a reduction in the Disproportionate Share Hospital (DSH) allotment beginning in fiscal year 2014, due to the assumption that the PPACA will make such allotments unnecessary; and extension of the authorization and funding for CHIP through 2015.

Required in 2014 are: the expansion of Medicaid coverage to low-income adults up to 133% of the federal poverty level; the use of Modified Adjusted Gross Income for determining eligibility for certain Medicaid groups, bringing new eligibility levels up to 138% of the federal poverty level; the prohibition of use of asset or resource tests for determining eligibility for Medicaid for certain eligibility categories; the implementation of an online application website for people to apply or renew services through Medicaid or the health insurance exchange, with state outreach to enrolled vulnerable and underserved populations; coverage of foster care children up to age 26; prohibition from excluding coverage of barbiturates, benzodiazepines and tobacco cessation products from the Medicaid program; and permitting hospital to make presumptive eligibility determination for all Medicaid eligible populations. For 2015, the FMAP for the CHIP program will be increased through September 30, 2019, for all the claims expenses.

With regard to the enhanced FMAP payments, **Director Armstrong** warned that each presents a "cliff," when the enhancement expires. He projected that the Department's Medicaid caseload will increase by 46% in 2014, when the PPACA is fully implemented, due to the inclusion of adults in the Medicaid program and the "woodworking" effect of bringing currently eligible, but not served children, into the program. Since such children are currently eligible, payment for them will be under the old FMAT rate. Idaho's share of Medicaid cost is expected to grow from 2014 through 2020, in both dollar and percentage amounts. Currently, adults comprise 27% of the Medicaid caseload, which is projected to increase to 42% in 2014. **Director Armstrong** stated that Idaho will need a delivery system willing to accept the capitative system, whether or not the PPACA is modified.

Representative Marriott asked if any of the program changes are optional. **Director Armstrong** replied that there are certain core programs that must be delivered, while others are optional through plan modifications approved by Centers for Medicare and Medicaid Services (CMS). However, removal of a program must be done with thought and care due to unintended consequences.

Director Armstrong moved onto discussion of the continued implementation of the Molina claims processing system. A copy of his PowerPoint presentation on this topic can be viewed at: www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1122_armstrong_mmis.pdf .

Director Armstrong's data showed an increase of the provider claims acceptance rate by the Molina system from 75% in July to 93.1% in November. The goal is to reach the upper 90s%. He explained that the Molina system identifies providers and services by codes. If the codes are properly used by the providers, the system works well. There are some 20,000 providers, with some smaller providers lacking sophistication on how to properly submit claims. In terms of dollars going out and claims paid, the Department is approaching historical averages. In terms of call center statistics, there has been tremendous progress. The average wait time has been reduced from over 38 minutes in July to two and a half minutes in November. The number of abandoned calls has been reduced from 50% to 7.1% over the same time period. The number of call center staff has been increased and their training has improved. Nine of the 18 major issues have been resolved, with a timetable set to resolve the remaining issues by the end of the year.

Senator Cameron stated that he is still hearing complaints, including delays in not getting back to providers with regard to questions. He encouraged better communication with the provider community. **Director Armstrong** said that he understood and would seek to provide more outreach.

Director Armstrong informed the task force that DentaQuest has changed its position on who could be in its provider network and is now allowing any dental provider who is willing to provide Medicaid services. The availability of providers to Medicaid participants is now getting close to what it was previously.

Senator Cameron commented that the change in networks had not been fully communicated between Blue Cross of Idaho and DentaQuest, resulting in a drop in providers. **Director Armstrong** said that is being addressed.

Representative Marriott expressed surprise that providers are willing to sign the DentaQuest provider contract due to a hold harmless clause on uncovered Medicaid claims. **Director Armstrong** stated that he did not know the details of the contract between DentaQuest and the providers. **Senator Cameron** offered that the master contract is between the state and Blue Cross. Blue Cross then contracted with DentaQuest to provide the service. DentaQuest, in turn, contracts with the providers. **Director Armstrong** added that the Department's contract with Blue Cross specifies the delivery results with quality of care standards. How the arrangement is crafted between Blue Cross and its contractee (DentaQuest) and, in turn, between DentaQuest and the providers, is not a state issue. **Steve Tobiason**, general counsel for Blue Cross, stated that DentaQuest is a multistate entity that provides Medicaid services. Although Blue Cross does not draft the contract between DentaQuest and the Idaho providers, it will talk to DentaQuest on this issue.

Senator LeFavour asked whether DentaQuest chooses its providers based on price. **Mr. Tobiason** responded that the contract between Blue Cross and its provider is not based solely on cost. **Senator LeFavour** inquired as to the criteria for the selection of dentists. **Mr. Tobiason** said that a number of factors are used by DentaQuest in selecting dental providers, including claims utilization, and that cost is not the sole issue.

Due to illness, **David Self**, the Senior Vice President and Idaho Regional Director for PacificSource, was unable to present to the task force. As a result, the presentations on proposed legislation by **Elizabeth Criner** of Veritas Advisors, LLP, representing MWI Veterinary Supply, Inc., and by **Ken McClure**, representing the Idaho Medical Association, were advanced on the agenda.

Ms. Criner discussed draft legislation (DRPAP 185) seeking to amend the Wholesale Drug Distribution Act to deal with veterinary pharmacies. A copy of DRPAP 185 can be reviewed in the Legislative Services Office. **Ms. Criner** informed that the amendments to that Act seek to cover properly licensed veterinary pharmacies. She has worked with Mark Johnston of the Board of Pharmacy on this proposed legislation and the Board of Pharmacy has voted to support it. The proposed legislation makes two changes to existing law: (1) provides a definition for "veterinary pharmacy;" and (2) provides an exception for veterinary pharmacies. The legislation reflects the practice in other states.

Representative Bilbao asked if Idaho veterinarians have been consulted on this proposed legislation. **Ms. Criner** answered that a copy has been sent to the State Veterinarian, who has not expressed concerns. **Senator Corder** stated that the Senate and House Agricultural Affairs Committees would like the opportunity to review the proposed legislation. **Senator Cameron** said that the task force would take the proposed legislation under advisement until its projected January meeting.

Mr. McClure provided the task force with three pieces of proposed legislation. Copies of these can be viewed at the Legislative Services Office. The first would require the Department of Health and Welfare to pay providers for Medicaid claims within 30 days after proper submission or be charged interest on the unpaid balance. **Mr. McClure** said that this is fair since the

Department charges providers interest on overpayments. In response to **Senator Stegner**, **Mr. McClure** explained that under this bill, the interest would not start to accrue until all documentation has been submitted.

The second bill would require the Department of Health and Welfare to provide 90 day notice to providers of a reduction in reimbursement for Medicaid covered services. Notice would be through the Department's website and to all professional associations whose members may be affected by the reduction.

The third bill is titled the "Health Care Professional Transparency Act." According to **Mr. McClure**, this bill would address the proliferation of medical providers that use the title "doctor." The bill would require such a provider to identify the type of doctor the provider is credentialed to be and would be enforced through the provider's licensing board. **Senator LeFavour** inquired as to whether the type of doctor would need to be written out or whether acronyms or abbreviations could be used. **Mr. McClure** stated that acronyms or abbreviations could be used. **Senator LeFavour** stated that she would prefer a full description. In reply, Mr. **McClure** said that a balancing test could be employed when space is an issue. **Senator Stegner** asked if there was a remedy if the licensing board failed to enforce the bill's requirements and whether the act might consider a complaint process. **Mr. McClure** responded that the licensing boards are generally trusted to govern their licensees appropriately but that he would take **Senator Stegner's** concerns under advisement. **Representative Bilbao** commented that his hospital now requires appropriately labeled badges on its personnel after some people were confused whether a physician or a physician's assistant was manning the emergency room on weekends. **Representative Marriott** asked if the January 1, 2012, date on the bill was correct. **Mr. McClure** stated that the intent was to give hospitals time to comply.

McClure informed the task force that the Idaho Medical Association was also interested in proposing a bill that would encourage physicians who have patients that should not drive to report such patients to the Department of Transportation. The bill would provide immunity to the reporting physician. The IMA is also supporting, but not sponsoring, legislation dealing with negligent credentialing and with any willing provider.

Richard Popper, the Director of the Officer of Consumer Information and Insurance Oversight (OCIIO) within the federal Department of Health and Human Services, addressed the task forceby conference call. **Mr. Popper's** PowerPoint presentation can be viewed at: www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1122_popper.pdf.

Mr. Popper informed that the OCIIO was established to implement market place insurance reform. One of its divisions deals with high risk pool programs. The federal program is the Pre-existing Condition Insurance Program (PCIP) that provides immediate coverage for individuals with pre-existing conditions until 2014, when the exchanges under the PPACA are implemented. Idaho has chosen to default to the federal government in running the PCIP, while retaining its own high risk insurance pool. In order to qualify for PCIP, an individual must: be a United States citizen or be lawfully present in the United States; have been uninsured for a minimum of six months before applying for PCIP; and demonstrate an inability to access commercial insurance.

An applicant may meet this last requirement by submitting a letter from the commercial carrier denying coverage, offering coverage with a rider, or, for children, offering coverage at 200% or more of the PCIP rate. PCIP applicants in Idaho must provide evidence that they cannot access commercial coverage. The OCIIO is soliciting Idaho for help and assistance in providing notice of the federal PCIP to individuals who have been declined for commercial insurance, training of agents, providers and consumer groups of the PCIP, and training Department of Insurance call center and consumer staff.

Senator Cameron asked how many Idahoans had applied for and been accepted in PCIP. **Mr. Popper** stated that 69 applications have been received, with 39 approved and enrolled in PCIP. **Senator Cameron** asked how an individual may apply for PCIP. **Mr. Popper** stated that paper and online applications are provided at PCIP.gov.

Senator Cameron asked what an individual must do to demonstrate an inability to obtain commercial insurance. The required documentation, according to **Mr. Popper**, is a denial letter or a letter offering coverage with exclusionary provisions. For children, an offer at two times the PCIP premium rate will suffice. **Senator Cameron** commented that one insurance carrier reported that its denial letter was not deemed proper and had to be revised. Although he may be speculating, **Mr. Popper** responded that the problem may be a denial coupled with an acceptance in Idaho's high risk pool. Perhaps the carrier denial letters should be restricted to provide reference to both the Idaho high risk pool and the PCIP. **Mr. Popper** stated that the OCIIO wants the PCIP to work, so adjustments may be required, perhaps on the OCIIO end. **Senator Cameron** suggested that the OCIIO and the Department of Insurance work together on the content of the commercial carrier denial letters.

Senator LeFavour asked what would happen if an individual does not receive a denial letter but an offer of coverage at a premium level that the individual cannot afford. **Mr. Popper** replied that premiums vary with the policy contents, including deductibles, co-pays, maximums and coverage and may not be related to health condition. The challenge is to shape affordability under these variables. The wording of the denial letter is key.

Senator Cameron asked whether PCIP pricing is competitive to the market depending on age and based on actuarial analysis. **Mr. Popper** related that the PCIP is subsidized with five billion dollars and operates at a loss. However, the premiums have an actuarial basis and represent an average of the high risk pool state premiums, adjusted regionally. **Mr. Popper** added that the PPACA sets limits on age bands.

Joy Wilson of the National Conference of State Legislatures addressed the task force by conference call. The topic of **Ms. Wilson's** presentation was the potential impact of the recent Congressional election on the PPACA. In advance of **Ms. Wilson's** presentation, **Senator Goedde** distributed an article from The Wall Street Journal, written by Janet Adamy and Neil King, Jr., to the task force members. A copy of this article may be obtained at the Legislative Services Office.

Ms. Wilson informed that the 112th Congress is now in the process of organizing. Representative

John Boehner will be the Speaker and Representative Nancy Pelosi will be the minority leader. The leadership in the Senate is unchanged. The House went from a Democratic majority of 255 to 180 to a Republican majority of 239 to 196, with five House seats still in play. The Democratic majority in the Senate is reduced. The election has resulted in a lot of new committee chairs, especially in the House and, consequently, new committee staff.

Regarding the PPACA, **Ms. Wilson** related that the slowing or repealing of PPACA is a Republican priority. The appropriations process would be the fastest way to affect the PPACA by attaching riders that would prohibit implementation. However, unintended consequence may result since some of the PPACA provisions save money and repealing those provisions will require identifying other offsets.

There is general bipartisan agreement on two amendments to the PPACA: (1) repeal of the 1099 reporting requirement for expenditures of $600 by small businesses; and (2) moving up from 2017 to 2014 as the deadline for allowing section 1332 waivers for state innovation. Regarding the first of these, the Internal Revenue Service believes that the existing reporting requirement increases tax collection. Repeal might have to include an offset to make it revenue neutral. Regarding the second, HHS and the Department of the Treasury would be required to review the state proposal to determine if it meets minimum PPACA requirements, including covering the same number of people and not increasing the deficit. If the PPACA requirements are met, the state would be able to use federal subsidies under the PPACA to implement the state program. **Ms. Wilson** reported that the Obama administration is working aggressively on the health insurance exchanges.

The Florida lawsuit brought by a number of states is challenging the individual mandate provisions of the PPACA. A decision on a pending dispositive motion is promised by December 16th. The Supreme Court has denied an effort to expedite the legal process. Other issues that have received the focus of the current Congress are deficit reduction, which usually means reducing grants to state and local governments, extending the Bush tax cuts and extending unemployment compensation.

Heidi Low, the Executive Director of the Idaho chapter of the American Cancer Society, discussed legislation her organization is proposing for introduction in the next legislative session. The proposal would increase the cigarette tax by $1.25, with the proceeds going to pay for tobacco prevention/cessation programs and to Medicaid programs. **Ms. Low** represented that the tax increase would raise an additional $48.2 million a year in revenue. A parallel increase in other tobacco products would raise an additional $2.9 million. **Ms. Low** related that such an increase in the cigarette tax would also result in a decrease in cancer deaths. No draft is currently available.

Ms. Low's talking points, "Three Reasons to Increase the Tobacco Tax in Idaho," can be viewed at: www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1122_low_handout.pdf .

The proposal was developed following an October 2010 telephone survey of 500 Idaho voters conducted by Moore Information. The survey results are accurate within four percent, plus or minus, with a 95% confidence level. Survey results indicate that while only 33% of Idahoans favor a sales tax increase and 31% of Idahoans favor an income tax increase, 71% of the surveyed Idahoans favor a tobacco tax increase. The only group in Idaho that was opposed to a cigarette tax

increase was smokers, although 67% of that increase agreed that such an increase would be fair. The PowerPoint of the report on this survey can be viewed at: www.legislature.idaho.gov/sessioninfo/2010/interim/healthcare1122_low.pdf .

Senator Corder asked if the projected revenues from a cigarette tax increase had taken into consideration a reduction in the sale of cigarettes. **Ms. Low** responded affirmatively, noting that a projected 19% decrease in youth choosing to not begin smoking because of such a tax increase had been taken into consideration. **Senator Corder** asked how the cessation in cigarette use had been calculated. **Ms. Low** replied that the estimates are based on the experiences of other states, as well as data from the CDC.

Steve Millard, the Chief Executive Officer of the Idaho Hospital Association, discussed peer review legislation that died in the House Health and Welfare Committee last session. The proposed legislation would keep peer review records exempt from discovery in lawsuits by physicians who sue a hospital over credentialing. **Mr. Millard** represented that physicians do not want to participate in peer review without immunity. No draft was currently available.

Roger Simmons, representing the Idaho Dental Hygienist Association (IDHA), discussed two legislative proposals. One would extend the ability of a qualified hygienist to perform specified restorative functions under the direct supervision of a dentist. The other would allow dental hygienists working in public health settings or in underserved areas to provide care directly to patients, to initiate care based on their own assessment of the patient's needs with specific authorization of a dentist, treat the patient without the presence of a dentist and maintain a provider-patient relationship. **Mr. Simmons** related that the proposed legislation would provide legislative recognition of what dental hygienists are already doing and what dental hygienists are being permitted to do in other states. **Mr. Simmons** also informed that there are still outstanding issues between the IDHA and the Idaho Dental Association, but they are working together to resolve any outstanding issues. No drafts are currently available.

The task force will schedule a future meeting on either Wednesday January 5, 2011, or Thursday, January 6, 2011. The meeting adjourned at 3:38 p.m.