MINUTES
Approved by the Committee
Healthcare Alternatives for Citizens below 100 percent of Poverty Level
Monday, October 24, 2016
9:20 A.M.
State Capitol -- Rm. WW17
Boise, Idaho

Co-chair Senator Hagedorn called the meeting to order at 9:20 a.m.; a silent roll call was taken. Members present: Senators Lodge, Thayn, Guthrie, and Jordan; Co-chair Representative Loertscher and Representatives Wood, Boyle, Vander Woude, and Chew; Legislative Services Offices staff: Elizabeth Bowen, Jared Tatro, and Jackie Gunn.

Other Attendees: Kelli Brassfield – Idaho Assoc. of Counties; Teresa Molitor – Foundation for Government Accountability; Mike Baker – Heritage Health; Scott Tiffany; Lee Flinn and Yvonne Ketchum-Ward – Idaho Primary Care Assoc.; Norm Varin – Pacific Source Health Plan; Fred Birnbaum – Idaho Freedom Foundation; Corey Surber – St. Alphonsus; Jim Baugh – DisAbility Rights Idaho; Toni Lawson – Idaho Hospital Assoc.; Shad Priest – Regence BlueShield of Idaho; Lisa Hettinger – Department of Health and Welfare; Linda Anderson, Kris Hooker, and Sylvia Chariton – American Association of University Women; Sharon Hawkins – Idaho Assoc. of Commerce & Industry; Judy Cross – Interfaith Alliance of Idaho; Francoise Cleveland – American Association of Retired Persons; and Betsy Russell – Spokesman-Review.

NOTE: Presentations and handouts provided by presenters/speakers are posted on the Idaho Legislature website: http://legislature.idaho.gov/sessioninfo/2016/interim/citizenshealth.htm; and copies of those items are on file at the Legislative Services Office located in the State Capitol.

Co-chair Senator Hagedorn called for a motion to approve the minutes of the September 28 meeting. Senator Lodge made a motion, Senator Jordan seconded the motion, and the minutes were approved by voice vote.

Co-chair Hagedorn invited Elizabeth Bowen, LSO Senior Legislative Research Analyst, to review the public comments/policy recommendations that she had received since the last meeting. Ms. Bowen reported receipt of 75 public comments/policy recommendations: 18 emails and 57 postcards. Of these, 12 supported Medicaid expansion or implementation of Medicaid expansion for a waiver; 60 supported nonspecific coverage for the "gap" population; and 3 opposed expansion of Medicaid.

Co-chair Hagedorn introduced Mr. Richard Cauchi, Program Director for Health Insurance, Financing, and Pharmaceuticals, National Conference of State Legislatures (NCSL). Mr. Cauchi presented his remarks regarding Section 1332 Waivers via phone. Mr. Cauchi explained that, starting January 1, 2017, states can pursue 1332 waivers, which would allow them to modify key parts of the Affordable Care Act (ACA). These waivers can propose broad alternatives or focus on fixes to the ACA's private insurance provisions, as long as they stay true to the goals and the consumer protections within the law. He noted that the ACA requires the state legislature to both file a bill and pass a bill in order to use a 1332 waiver. He added that there is no deadline for filing for a waiver. Mr. Cauchi detailed the following state waiver requirements and prohibitions:

Four innovation waiver requirement areas (guardrails):

- Comprehensive Coverage – States must provide coverage that is "at least as comprehensive" as coverage absent the waiver.
- Affordable Coverage - States must provide "coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable" as coverage absent the waiver.

- Scope of Coverage – States must provide coverage to "at least a comparable number of residents" as would have been covered without the waiver.
- Federal Deficit - The waiver must not increase the federal deficit.

Limits of 1332 waivers:

- States cannot waive non-discrimination provisions prohibiting carriers from denying coverage: Guaranteed issue and related rating rules increasing premiums based on medical history.
- States cannot waive provisions that guarantee equal access at fair prices for all enrollees.
- 1332 waivers are not Medicaid waivers, but a state may develop a companion Medicaid waiver, typically an 1115 waiver, along with a 1332 waiver, to achieve policy goals.

Mr. Cauchi spoke to the possibility of leveraging and coordinating 1115 and 1332 waivers, in order to make changes to test innovative approaches in Medicaid (1115 waiver), or individual or small group insurance markets (1332 waiver). He also reviewed the waiver-related actions taken by others states, including:

- 17 states have considered 1332 waiver legislation; of those, 6 states (Alaska, Minnesota, Ohio, Oklahoma, Rhode Island, Texas) have enacted some sort of law relating to a 1332 waiver and 4 states (Hawaii, Massachusetts, Vermont, and California) have enacted both a waiver law and filed with Health and Human Services (HHS) and Treasury Department.
- 6 states (Arkansas, Colorado, Georgia, Maine, Minnesota, and South Carolina) have filed bills but have not enacted legislation.

Mr. Cauchi noted that Table 2A of his handout provides language for the Section 1332 requirement for a state statute. Summarizing his remarks, he opined that innovation waivers do give states freedom to improve on the health clause coverage framework but cautioned that the waivers are not a magic wand that will allow states to avoid the ACA. Rather, states' efforts to innovate under the law must share the ACA's focus to improve coverage access, affordability, and comprehensiveness for all Americans, including the most vulnerable.

- Referring to Ohio's request for removal of the employer and individual mandates and fines, Co-chair Hagedorn asked for more details regarding how the Internal Revenue Service (IRS) was separate from the waiver process. Mr. Cauchi noted that this is untested territory for the federal government. There is precedent for states doing tax policy that varies from the federal policy, but in this instance, it is an issue of how the policy would be administered. For instance, in Ohio, there is speculation that a state revenue office would have to take over the administrative piece, and this could mean increased responsibility for the state.
- Rep. Wood asked for more details regarding the information presented relating to emerging issues and state flexibility (page 6 of the handout). Mr. Cauchi responded that his intent was to restate the general areas that are allowable under the 1332 waiver, and to highlight some things that can be done without a waiver. He added that his review of current state exchanges revealed that Idaho is one of only two states to have more insurers in 2017 than in 2016.
- Rep. Chew asked for an example of applying the four criteria, with respect to the removal of the employer and individual mandates. Mr. Cauchi remarked upon the usefulness of actuarial tables, and he advised that a state must evaluate the financial consequences and the number of people actually receiving coverage. He also briefly discussed the meaning of the nondiscrimination provisions of the ACA and other related prohibitions.
- Sen. Thayn asked Mr. Cauchi to discuss the debate surrounding Colorado's failed bill. Mr. Cauchi agreed to research the single-payer aspects of the debate and provide the committee with relevant information, in addition to single-payer state reports that might be used as a model.
- Noting that the entire healthcare delivery system has issues, Sen. Guthrie asked for more details concerning the Arkansas legislature's effort to integrate some of the things it did with the waiver

into the private sector. Mr. Cauchi identified that, in January 2015, Arkansas launched a formal planning process and put in writing a number of ideas at the insurance end that would tie to the Medicaid end. He also explained why the Arkansas report would be a good resource for the committee's discussion.

- Rep. Chew asked for more details regarding the single-payer concept for Idaho. Mr. Cauchi summarized the concept, explaining that, instead of depending on commercial insurance plans, the structure more closely resembles Medicare, in the sense that all of the payments would originate from the government in some form. In November, Colorado will have this concept on the ballot as a constitutional question. He noted that single-payer proposals have been filed in a majority of states over the last twenty years. And, prior to the ACA, a number of states looked at the topic, but none adopted a single-payer plan. Co-chair Hagedorn commented that the Veterans Administration and the military systems are great examples of single-payer systems, as is Cuba.

After a ten-minute break, Co-chair Hagedorn introduced Ms. Deborah Fournier, Medicaid Director, New Hampshire Department of Health and Human Services. Ms. Fournier laid out the details surrounding the 2014 enactment of authorizing legislation that enabled the Medicaid program to open the eligibility category for expansion adults. The legislation required that the state pursue an 1115 waiver that would allow the state to use the federal match for the expansion adults, and then use it to purchase qualified health plans certified for sale on the marketplace. The state was required to submit the waiver and receive approval of the waiver by March 2015. Failure to meet those deadlines would mean that the program would end sixty days later. Continuing, she stated that the initial authorizing legislation mandated that, if the state received approval from the Center for Medicare and Medicaid Services (CMS) for this waiver, the program would run and the individuals would be moved from the traditional Medicaid into the qualified health plans for 2016. The program would only continue until the favorable match of 100% Federal Medical Assistance Percentages (FMAP) concluded at the end of 2016, unless the statehouse reauthorized it.

- Co-chair Hagedorn asked if New Hampshire's expansion was using Medicaid to pay for the insurance of individuals on its exchange? Ms. Fournier assented, explaining that they were required to submit a waiver requesting that; and in order for the program to continue throughout 2015 and all of 2016, they had to obtain approval for that waiver by a date certain in 2015. They took the rest of 2015 to construct the program. The expansion adults started their commercial market coverage in the qualified health plans in January. They were covered in the intervening months by the traditional Medicaid managed care. The permission they sought, and were ultimately granted by CMS, was to use the favorable Medicaid match to purchase products certified for sale on the individual marketplace. So, in essence, they used the public dollars to purchase the commercial insurance. Following up, Co-chair Hagedorn asked if that was for everyone qualifying for Medicaid in the state or for a "gap" population? Ms. Fournier replied that it was for all of the expansion adults. Consequently, everyone with income, no matter where they fell in the income range for the Medicaid eligibility group, used those dollars in 2016 to purchase commercial insurance. She noted that there were a few exceptions.
- Rep. Wood asked if, prior to expansion, all Medicaid populations were on managed care? He also asked if she could provide the last ten years' average annual rate of increase cost to that managed care program? Ms. Fournier responded that New Hampshire has had Medicaid managed care since December 2013. Because of this, a decade's worth of trend is not available. In the decade, 2000 to 2010, the annual growth rate was between three and four percent. Rep. Wood asked, when they were transferred over to the state exchange and to private insurance, whether those were managed care or were they fee-for-service contracts? Ms. Fournier stated that it depends on the commercial carrier's involvement. Because New Hampshire is essentially acting as the third-party payer, the state pays the premium; it does not dictate to the carriers what payment arrangements are entered into with the providers. New Hampshire's model is one where the state pays monthly: the premium to the carrier; the deductible, if there is one; and the cost-share reduction. She guessed that the vast percentage of the carriers pay their providers

in a fee-for-service arrangement; although, some are beginning to experiment with value-based purchasing. Rep. Wood asked if they had a federal exchange in New Hampshire, and if she could identify the annual increase in those insurance policies? Ms. Fournier explained that New Hampshire has a federally facilitated exchange, and she offered to provide the annual increase data to the members after she consults with her contact at the state's Department of Insurance. She added that they are bound by their contract not to exceed what their projected growth would have been within a managed care setting. She noted that they have just seen the carrier rates for calendar year 2017, and they are still hitting their marks for budget neutrality calculations. Moving forward, Rep. Wood asked her to identify who is actually paying the bill for the state's dollar share of the expansion population, and to also identify the source of those funds.

Ms. Fournier continued with her presentation, stating that 48,000 individuals transitioned from the Medicaid managed care product to their federal marketplace in January 2016, and noted that this doubled the number of people in the federal marketplace in New Hampshire. She explained that there is a component of nonfederal share, anticipated to be between four or five percent, and it begins next year. The enacted legislation requires that this nonfederal share for the expansion adults be made up by voluntary donations from charitable foundations, such as hospital associations, and possibly from commercial carriers. She offered to provide the language of the statute, and she noted that the exchange sunsets in 2018.

- Co-chair Hagedorn asked if New Hampshire's premium tax will be used as part of this five percent charitable fund offset? Ms. Fournier answered "no," and she explained that the premium tax portion that is attributable to the revenues based on premiums, which paid for expansion individuals, will go toward the nonfederal share. That amount will be applied before this remainder amount. The remainder amount will be the net of federal share, premium tax attributable to the individuals covered by the program, and the commercial carriers pay no more than 50% of the remainder amount. Following up, Co-chair Hagedorn asked if there were any expectations that the charitable giving from the hospital associations or the insurance providers would not be reflected in their costs? Ms. Fournier stated there was nothing in the legislation about this; although she added there was public conversation about it, and the parties were all asked, "what do you say about paying this portion?"
- Rep. Wood asked Ms. Fournier if New Hampshire has a state version of the Disproportionate Share Hospital (DSH) program - a program where you can have intergovernmental transfers or the ability of hospitals or other providers to tax themselves, in order to put up the money to draw down the federal funds? Ms. Fournier stated there is nothing about DSH in their expansion legislation, though there is something called the "Medicaid enhancement tax," which is the tax levied on hospitals.
- Sen. Jordan recognized that no general funds are used for the match, but that the requirement for contributions outside of other state funds are for a portion of the state match. Ms. Fournier responded that it is meant to cover the entire state match. Their statute states that, beginning in 2017, no general funds may be used to pay for expenses related to the expansion. Following up, Sen. Jordan asked Ms. Fournier to discuss the possible revenue sources that will be used toward the match; for example, Idaho's Catastrophic Health (CAT) Fund. Ms. Fournier compared their 2014 High Risk Pool to Idaho's CAT Fund, noting that their High Risk Pool sunsetted. New Hampshire's towns and cities are identified as the "payer of last resort" in paying medical bills for those who can't afford to pay them. She stated that the towns and cities have seen significant drops in those budgets. Continuing, Sen. Jordan asked what was New Hampshire's estimate for the population entering the program, compared to the actual numbers? Ms. Fournier stated that when the effort started, they estimated that 60,000 people would likely be eligible and sign up; she recounted that they have just hit 50,000 this fall.
- Sen. Thayn asked Ms. Fournier if she could explain why their estimate was so accurate? Ms. Fournier answered that they wanted to be relatively conservative with the estimate. When the

projections originally came out, there was a low, medium, and high take-up scenario; the state went with the high take-up scenario.

- Sen. Guthrie asked whether those services provided by New Hampshire are paid for by the federal government when the waiver is approved? Ms. Fournier explained that when they move to the private market, she will take the dollars used to pay the private commercial carriers at the heightened FMAP rate for the remainder of 2016. Federal dollars pay for the premiums and the services required. Regional Cooperative (RC) services are paid for and provided by Medicaid.
- Co-chair Hagedorn asked, when 48,000 went on the exchange, what happened when someone from that population moved off? Ms. Fournier stated that the participants on the exchange pay monthly, so the eligibility is still driven through Medicaid. When someone loses eligibility, they aren't in her monthly count, so there is one less person to pay a premium and a deductible. Following up, Co-chair Hagedorn asked if this movement on and off the exchange is tracked monthly? Ms. Fournier explained the Medicaid law mandates an annual census. She added that the system is able to track the individuals by unique identifiers.
- Rep. Vander Woude asked how the participants were unenrolled, and how long that process takes? Ms. Fournier explained that open enrollment is for the season, and eligibility for Medicaid is never closed. Because of this, the state has agreed to provide services to these people. In turn, the carriers have agreed to accept the new individuals throughout the year. She added that this happens through a state portal, and this is the only reason why the loss of Medicaid eligibility allows them to shop on the exchange, as they can come on at any time.
- Sen. Jordan asked if employers have a requirement to report the eligibility of their employees or inform the employees of their options? Ms. Fournier stated she could not recall if employers were required to report the eligibility or inform the employees of their options.
- Rep. Chew asked, with regard to medications, what lessons New Hampshire has learned in educating the new exchange individuals about their carrier/plan selections? Ms. Fournier responded that, during the plan selection process, they would have emphasized the importance of reviewing each carrier's medication list. Ms. Fournier also commented on the challenges of deploying their 'auto-assignment' technology, explaining how the new individuals in the exchange were confused when they couldn't find their preferred physician in the network to which they were auto-assigned.
- Co-chair Hagedorn asked if New Hampshire's formularies are available on the exchange? Ms. Fournier stated that the products they have purchased on behalf of their clients are products that are certified for sale and sold to people who are not Medicaid eligible through Healthcare.gov. She noted it just wasn't possible for Healthcare.gov to facilitate the purchase with the Medicaid dollars, so New Hampshire had to do it themselves. Following up, Co-chair Hagedorn asked if Ms. Fournier would provide the committee with copies of their co-pay assignments. Ms. Fournier agreed to send a report to Sen. Jordan, who in turn agreed to send it to the committee co-chairs.

Co-chair Hagedorn addressed the members with his presentation, which included the following observations and suggestions:

- Focus should be on bending the cost curve of providing healthcare.
- Progress will be made only by bending the curve of the expense to the provider.
- Leverage the successful State Healthcare Innovation Plan (SHIP) program, add approved legislative sideboards, and get everyone into a SHIP-like program by January, 2018. He noted that with a population of 300,000, the cost can be driven down. With estimates of this to be $30 million, he suggested using this as a straw man to discuss and draw upon.
- Give Director Armstrong, Health and Welfare Department, and Director Cameron, Department of Insurance, the responsibility of figuring out what waivers to negotiate with the federal government, in order to remove the individual and employer mandates. If the federal

government will remove the mandates, then use the leverage we have now, the $40 million for SHIP, and move all the population into this type of program.

- Help Idaho's working poor with education, coaching and better jobs through training.
- Create a platform of primary care that is not dependent on shifting federal programs.

After lunch, Co-chair Hagedorn asked the members to discuss and consolidate ideas.

- Rep. Wood proposed taking the $15.5 million from the Millennium Fund and putting it into some kind of Primary Care Access Program (PCAP) formula for the "gap" population. If the Medicaid basic plan is approaching what we want in bending the cost curve, he stated that the big issue is money. Going forward, the Millennium Fund dollars are the only dollars being contributed. He suggested the provider/carriers bring forward a bill that puts up the money to match the federal dollars. He advised that there should be a prohibition against the use of state moneys for anything other than the Millennium Fund dollars.
- Sen. Thayn stated that parts of the PCAP proposal are very intriguing and should be considered along with Co-chair Hagedorn's proposal for how to bend the cost curve down. He suggested weaving the most appealing aspects of several of these proposals together.
- Rep. Vander Woude stated the priority is to find a way to get primary care to the "gap" population. He proposed that the members consider the following steps right now: allocate $30-50 million to the clinics via grants, with the money coming from the Millennium Fund and from money saved from the CAT Fund; create an Access Idaho program that is modeled after Access Northwest; hold people accountable for their healthcare choices by putting into place consequences for those who choose not to make better health choices; do something for the people in the "gap" population now, using the savings from the CAT Fund or from the Millennium Fund to provide at least some primary care and then look to alternatives; and have the state cover the malpractice insurance for those physicians who wish to donate their services, or have the state pay for the required training/education hours for volunteers, like the program in place in Florida.
- Sen. Jordan suggested keeping Medicaid expansion on the table. She noted the 5 to 1 return from the SHIP program. She opined that primary care is only one piece of the puzzle, and it will not solve the problem. She emphasized that a priority should be to address coverage of the catastrophic situations.
- Sen. Lodge emphasized that there is a real need for doctors in rural areas. She also suggested that malpractice reform should be investigated, and the medical education program in partnership with the University of Washington School of Medicine and the states of Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) should be tweaked, so that a greater percentage of specialty-trained young people come back to Idaho. Also, she suggested attaching sideboards for primary care physicians, in order to bring down the costs. She opined that some of the ideas brought forward today by members are going in the right direction, and added that accountability is important before the state is in a crisis situation.
- Sen. Guthrie stated that primary care can be a springboard for efforts moving forward. He noted that the members all agree that something must be done. He suggested that they should determine what is the ultimate goal of the state. If it is to transition to comprehensive care and have the state fund it, the Legislature must step up to the plate financially.
- Sen. Thayn observed that, though members wish to reduce overall medical costs for everyone in the state, he is not willing to refuse federal dollars on principle. He added there are too many federal restrictions on the primary care side.
- Co-chair Hagedorn reiterated his support for a state-controlled primary care program. He emphasized the need to leverage the success of the SHIP program.
- Rep. Boyle suggested incentivizing some of the large hospitals to provide medications at their cost. Other suggestions included: increasing the number of seats available for the WWAMI

program to in-state medical school students; allowing nurse practitioners to do more than they have been allowed to do in the past, like the program underway in Nevada; and helping volunteer practitioners with malpractice insurance. She also voiced her opposition to forcing people onto government programs in instances where they have to sign over their assets.

- Rep. Wood cautioned against creating provisions associated with state mandates, indicating that they are worse than federal mandates.
- Rep. Chew stated that solutions must work for everyone, must include full care, and must be sustainable.
- Sen. Guthrie commented that when you solve problems, you have to play by the rules; so, the committee must focus on making the best decisions, given the rules.
- Co-chair Loertscher noted that, historically, every expansion has cost more than predicted; the number of people served has been bigger than estimated; and utilization has always increased. He opined that, if we are going to do any part of Medicaid expansion, we need to do some of the SHIP program. His specific observations and suggestions included: the state must step up to the plate with funding to support the mentally ill and the disabled to ensure there is coverage in Medicaid; when people can go into the market themselves, more physicians like Dr. Brooks can be encouraged to help; we should provide the incentives to encourage personal responsibility; and any movement in the direction of Medicaid expansion should mean the elimination of the CAT Fund and the county medically indigent fund. Co-chair Loertscher stated that, while the committee may not produce draft legislation, their report should embrace the agreed-upon concepts.
- Co-chair Hagedorn commented on why dependency on volunteers is not a good business plan. He emphasized that the real cost of services are the catastrophic costs. He noted that they haven't controlled costs at the source of delivery. He stated that their report will educate the legislators that they have to do something to begin bending the cost curve. He indicated that Ms. Bowen will write the report, and then asked members to note possible consensus areas.
- Rep. Wood stated that Millennium Fund moneys should be used for the "gap" population.
- Sen. Jordan reiterated that primary care is just one component in addressing the problem of supporting those in the "gap" population.
- Sen. Lodge emphasized the need for getting the WWAMI graduates into the rural areas, as well as the need for providing malpractice insurance for the retired doctors who volunteer their services. Co-chair Hagedorn observed that the choke point for getting more WWAMI graduates to the rural areas is that there are not enough in-state residency programs in the specialty areas of medicine, and there is not enough graduate medical education (GME) training. He opined that these residencies need to be created in Idaho. He suggested that, as with the SHIP program, we could set the boundaries for what we want to have happen, and then have the Health and Welfare Department and the other experts provide us with an assessment for anticipated costs. At that point, we would determine the available funding, and the committee could put a bill together for the Legislature to consider.
- After some discussion by committee members, Co-chair Hagedorn stated that the members all appear to agree on reducing the spending in the CAT Fund and the county medically indigent fund.
- Senator Jordan commented that it would be helpful to get consensus on what the term "cost effective" means going forward.

At the conclusion of their comments, Co-chair Hagedorn asked the members to review the calendar and called on Ms. Bowen to discuss her plans for drafting the final report. Ms. Bowen stated that the committee's final report must be submitted by November 30. Given that information, the committee decided to meet on Tuesday, November 22, at 9.a.m for one hour. Ms. Bowen agreed to send the members a checklist that will include all of the ideas discussed at the meetings. Members will indicate their preferences or ideas and return their checklist to Ms. Bowen (by Friday, November

11). Using this information, Ms. Bowen will create a final report draft and send it to the members for their review (on Tuesday, November 15). This will allow the members to review the draft and make corrections before the next committee meeting on Tuesday, November 22.

The meeting was adjourned at 2:30 p.m.