MINUTES
Approved by the Committee
Healthcare Alternatives for Citizens below 100 percent of Poverty Level
Monday, August 29, 2016
9:00 A.M.
State Capitol, Room WW17
Boise, Idaho

Co-chair Senator Hagedorn called the meeting to order at 9:00 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 Office staff Elizabeth Bowen, Jared Tatro, and Jennifer Kish.

Other attendees: Deborah Bachrach - Manatt; Fred Birnbaum - Idaho Freedom Foundation; Elwood Kleaner - Conex; Francoise Cleveland - AARP (Idaho); Kris Hooker - AAUW (Boise Branch); Liz Woodruff, Lauren Necochea - Idaho Voices for Children; Pat Day Hartwell; Aaron White - AFL-CIO (Idaho); Lee Flinn - Idaho Primary Care Assoc.; Kelli Brassfield - Idaho Assoc. of Counties; Stephen Thomas - Idaho Association of Naturopathic Physicians; Luke Cavener - American Cancer Society Cancer Action Network; Dr. Jim Brook; Betsy Russell - The Spokesman-Review; Teresa Moliter - Foundation for Government Accountability; Scott Shurtleff - Project Access Northwest (via telephone).

NOTE: presentations and handouts provided by the 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 Hagedorn called for a motion to approve the minutes of the August 11 meeting. Sen. Jordan made a motion, and Co-chair Hagedorn called for a vote. Minutes were approved by voice vote.

Co-chair Hagedorn called upon Elizabeth Bowen, LSO Senior Legislative Research Analyst, to present material requested by committee members. Ms. Bowen summarized the 82 responses she had received from the public in regard to opinions on healthcare solutions: 34 advocated a traditional Medicaid expansion or the use of waivers; 20 were advocating a comprehensive package for coverage of those in the "gap;" 22 had no specific solution but supported efforts to have coverage for those in the "gap;" one response advocated that healthcare become a public utility and that all Idahoans be covered by it; and five responses did not advocate a solution but shared personal experiences of difficulties with healthcare coverage. Ms. Bowen then discussed her general overview of Medicaid Expansion and Waivers as requested by the committee.

Co-chair Hagedorn then called upon Jared Tatro, LSO Principal Budget and Policy Analyst, to discuss his requested material. Mr. Tatro explained that the Medicaid Estate Recovery Program recoups funds from eligible Medicaid participants' estates after their death. His handout explained when and why such a recovery would be pursued, identified Idaho statute and rule references, and provided budget data for the previous ten years of the program.

- Co-chair Loertscher inquired whether this was a federally mandated program? Mr. Tatro replied that all 50 states had a program, and the operations of each were carried out differently. He would verify if it was federally mandated.
- Co-chair Loertscher asked Mr. Tatro to further explain the second example listed on the handout. Mr. Tatro stated that claims would not be made until the participant was 55 years old; the time began at age 55 and concluded upon the participant's death. He offered this additional example: a participant had $10,000 worth of claims and a home paid-off and valued at $100,000; the program could attempt to recover the $10,000 after the sale of the home; however, the program had to determine whether it was worth the expense to recover the $10,000.

- Co-chair Loertscher inquired whether the recovered funds were sent to the federal government or whether the funds were viewed as an offset to later appropriations? Mr. Tatro explained that the state would pay on the claims and the reclaimed funds would be returned to the account. Hence, the money would be used in lieu of additional drawdown or in lieu of general funds.
- Co-chair Hagedorn inquired the value of the unclaimed funds? Mr. Tatro responded that he did not know that value, but expected it to be reported in the budget, due September 1.
- Sen. Jordan inquired whether the attempt to recover funds would put an additional hardship on surviving family members? Mr. Tatro shared that the decision to recover funds took that into consideration in deciding to reclaim funds; he noted that a lien could be placed on property, estate, trust, etc. to be paid upon the family members passing.
- Co-chair Hagedorn asked Mr. Tatro to verify that the state would receive 29 cents for every dollar reclaimed. Mr. Tatro commented that the estimate was very close to that number.
- Rep. Vander Woude questioned why the recovery amount was so much lower in 2011 than previous years? Mr. Tatro explained that, per the asterisk on the report, the data for 2011 was incomplete because the new MMIS (Medicaid Management Information System) was implemented and there were many issues: difficulties in tracking data, claims being withheld, budget shortfalls, etc.

Mr. Tatro then discussed his FMAP handout (Federal Medical Assistance Percentages) charting comparisons between Idaho and Maine. [From previous meetings: FMAP rates are the percentage rates used to determine the matching funds rate allocated annually to certain medical and social service programs.] In his comparison, if all items were constant (eligible participants, services provided, etc.), for every 5% change, the state would need about $83 million additional matching funds.

- Rep. Vander Woude inquired whether the FMAP rate would proportionately decrease to a state's increase in income? Mr. Tatro commented that such a summarization was essentially true; however, it was also comparative to the other states. Per information provided earlier, Idaho's per capita income increased over the last few years, but not in comparison to the national average of other states.

Co-chair Hagedorn called upon Deborah Bachrach, Partner with Manatt, for her presentation Medicaid and the Coverage Gap: Overview of Options and Economics. Her presentation covered her knowledge of what other states had implemented and what implementations worked or did not work. Ms. Bachrach stated that she had worked with the state of New York for approximately three years (2007-2010) in negotiating the Affordable Care Act (ACA). Since then, she had worked through Manatt with other states' providers, foundations, health plans, and consumer groups on Medicaid coverage issues (slide #2). Highlights and additional information from the presentation regarding Coverage Options (slides 4-15):

- Alternative Medicaid Expansion - states that expanded using a federal waiver or a combination of waivers; waivers are to "personalize" state programs.
- Alternatives for discussion: coverage connected to employment requirement - denied by CMS (Centers for Medicare & Medicaid Services); benefits & coverage - must cover the 10 essential benefits, exclusion may be made for non-emergency medical transportation.
- Premium = initial payment for coverage; state may not impose a premium if participant earns 150% below the federal poverty level (FPL) without a waiver.
- Indiana secured many waivers early in the process; CMS reports that such aggressive waivers as approved for Indiana would probably not receive approval today.

- Cost sharing is permitted without waiver being filed; many states do not impose; may impose up to an $8.00 fee to participants below 100% FPL and may charge 10% of service cost for participants above 100%.
- Appealing attributes of Health Savings Accounts (HSAs): participant can easily see the cost and that the bill was paid with the amount already set aside; often coupled with an incentive program to be healthier.
- Premium assistance for Employer Sponsored Insurance (ESI) and Qualified Health Plans (QHPs) made the most sense but Medicaid has difficulty keeping track of all the nuances of everyone's policy.
- States lose the 100% federal match at the end of 2016.
- Savings generated from expanded coverage have enabled most to cover costs to 2021.
- Many states that expanded after 2014 included in their legislation a provision that, if Congress were to change the federal matching rate, the state's expansion would sunset/be void; this is permissible per CMS.

- Rep. Vander Woude asked Ms. Bachrach to verify that a state could charge a fee/co-pay for a non-emergency ER visit under current Medicaid rules? Ms. Bachrach responded that he was correct: under current Medicaid rules, a state must cover non-emergency use and may charge a fee of up to $8.00 for such purpose.
- Sen. Jordan inquired whether any states implemented a healthy behavior incentive and were moving toward a managed care model? Ms. Bachrach noted that Michigan and Indiana were fully Medicaid managed care.
- Sen. Jordan asked whether, in the situation where Idaho already had a managed care model, a waiver would be needed to include healthy behavior incentives? Ms. Bachrach responded that it *might* not be needed, it was all dependent on features of the program.
- Rep. Wood observed that when Idaho individuals at the 100-138% FPL went to the exchange (remember that Idaho has not expanded), federal funds were available by way of the IRS (Internal Revenue Service); however in the Arkansas model (which has expanded), funds were not from the IRS but rather from Medicaid dollars and state matching funds to cover the premiums. Ms. Bachrach noted that Rep. Wood was correct in his statement. Additionally, Arkansas and New Hampshire were matched 100% by federal dollars for the first three years of their program; for 2017, the match becomes a 95% federal dollar match. Rep. Wood then inquired whether it was a fact that any state having such a program in 2020 would be using 10% of state matching funds to pay for premiums? Ms. Bachrach stated that Rep. Wood was correct.

Highlights and additional information from the presentation regarding the Economics (slides 17-26):

- Cited using the Milliman report on Idaho for this section.
- Correction on slide #17: "Parents with incomes from ~~35%~~25% FPL up to 138% FPL"; also for figure in box below the previous statement.
- Federal Disproportionate Share Hospital (DSH) funds, which help compensate hospitals' uncompensated care, will decrease (2018) because ACA assumed that all states would expand and DSH funds would no longer be needed as the state plans absorbed those costs; can move DSH dollars (70% match) to cost for new adults and receive 95% match.
- Drop in those labeled as "disabled" (6-7%) as folks moved to new adult group; many don't want to go through disability determination; area for Idaho to consider for savings.
- Pregnant women can be shifted from regular match to enhanced match; area for Idaho to consider for savings.

    - Savings for counties were very state specific; sheriffs and EMS personnel were very invested in expansion discussion due to frustrations with repeat offenders of substance abuse and those with mental health issues.
    - Commented that because Maine's expansion was pre-ACA requirement date, it did not benefit from the enhanced matching rate formula; so, do not compare Idaho to Maine.
    - Defined the term "take-up rate" (slide 26) as those individuals who were Medicaid eligible and actually enrolled.
- Co-chair Hagedorn requested Ms. Bachrach discuss in further detail the concept of cost shift and its effects. Ms. Bachrach explained that hospitals incur uncompensated care because of EMTALA. [Emergency Medical Treatment and Labor Act of 1986 - a federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay] Often, a small portion of that loss is covered by state, county, and federal programs (not Medicaid or Medicare); so, the hospital then shifts a portion of the expenses to private insurers, which causes premiums to rise.
- Sen. Thayn inquired whether any study had been done on the impact to providers or provider satisfaction, considering that Medicaid payment rates often underpaid the requested rate? Ms. Bachrach commented that Medicaid payment rates varied too much among states for a fair study. For example, in Michigan, doctors were more willing to accept Medicaid after expansion even though there was no increase to the rate of payment. She noted that many hospitals and physicians were frustrated with the lower Medicaid repayment rates, which was a reason to embrace the Arkansas and New Hampshire models because the provider repayment rate was often at a commercial rate.
- Co-chair Hagedorn inquired whether SNAP (Supplemental Nutrition Assistance Program) program adults could be moved to a higher matching rate? Ms. Bachrach explained that Idaho currently was not receiving any match because those individuals were uninsured. However, those individuals were eligible in an expansion scenario where you had permission to move them over to the state Medicaid program.
- Sen. Thayn shared a number of thoughts, which he encouraged Ms. Bachrach to comment on. Considering that the US spends approximately 17% of GDP on medical costs, he commented that an expansion program: 1) did not address the third-party payer system, and so no reduction in costs occurred there; 2) perpetuated the continual creep of federal rules and federal involvement in state operations; 3) continued our dependence on federal government funds, thereby contributing to the already incredible federal deficit; and 4) federal entitlement programs, like Medicaid and food stamps, don't encourage folks to be independent. He felt that the solution was to consider Idaho answers with Idaho funds to reduce the overall cost of medical care. Addressing his third-party payer concerns, Ms. Bachrach responded that Medicaid expansion increased the state's leverage to influence/improve health care coverage. On the issue that Medicaid was a federal/state program (where the state was reimbursed at 70% of the expense and 95% at the enhanced rate), she commented that the federal government was unlikely to remove itself and leave the money. On the federal deficit, she stated that studies found that removal of the ACA would have a negative impact on the federal deficit. And finally, on federal entitlement programs increasing dependency, she noted that Medicaid was health insurance. It started in the 1960s as a welfare program and one could not obtain its benefits unless one was also receiving welfare; however, in 1996 it was unlinked from welfare and was purely health insurance.
- Rep. Vander Woude asked what time frame existed on an approved waiver and whether a renewal process existed? Ms. Bachrach explained that waivers could be effective for up to five years; waiver renewals generally do not exceed three years. She noted that CMS could deny a renewal.

- Rep. Vander Woude inquired whether the new administration would have any effect on waivers or waiver renewals? Ms. Bachrach noted that a new administration could have an effect, but the fact remained that CMS was the authority on the subject and it would attempt to stay consistent with its previous decisions.
- Co-chair Hagedorn inquired whether states had included sunset provisions on the effectiveness of waivers? Ms. Bachrach reported that she did not know of any such situations; however, some states (MI, AK, NH, and MT) had included provisions that the state had to apply for a waiver by a certain date and the waiver had to be approved by an additional date. She cautioned putting language in statute because it may be left in statute, when circumstances changed. Co-chair Hagedorn commented that the uncertainty of ACA requirements and changing matching rates were factors of concern to committee members, so it was good to know of such a tactic. Ms. Bowen commented that SB 1205 from 2015 included a sunset clause.
- Sen. Jordan asked whether there existed a database containing examples of waivers and outcome-based requirements proposed by other states? Ms. Bachrach reported that there were studies, both pre- and post-ACA, on the impact of premiums and costsharing. She noted that every waiver required an evaluation, but those were done by each state and not by a third-party entity.
- Sen. Jordan then requested Ms. Bachrach to explain how New Hampshire was able to establish a delayed expansion. Ms. Bachrach reported that it was dictated by language in the expansion legislation. New Hampshire had established a date that the state Medicaid agency had to have filed a waiver for mandatory premium assistance for QHPs; and additionally, if the waiver was not approved, there was a sunset clause on the expansion.
- Sen. Guthrie asked whether there had been a net economic impact study on state savings? Ms. Bachrach noted that Manatt had only considered uncompensated care in its study (slide 18). She noted that New Mexico and Colorado had done their own studies and that she could provide those to the committee members. Additionally, a study in *Health Affairs* the previous week (August 22) had concluded that the drop in uncompensated care cost was greater than the cost of expansion. Co-chair Hagedorn requested that Mr. Tatro look into that report.
- Sen. Guthrie then asked whether Ms. Bachrach could provide information regarding the expectation of insurance rates to normalize/stabilize since more individuals were in the group? Ms. Bachrach responded that a HHS (Health and Human Services) ASPE (Assistant Secretary for Planning and Evaluation) report found that premiums were approximately 7% lower in expansion states. She commented that she could not speak to how or whether rates had increased.
- Sen. Lodge inquired whether there were studies available regarding the reduction of the cost of healthcare, especially pharmaceuticals and medical procedures? Ms. Bachrach reported that increases in healthcare were due to the increased costs for pharmaceutical, physicians, hospitals, etc., and premiums reflected that trend. She suggested that states use Medicaid as their leverage for affecting the market; such as, the change from fee-for-service to a value-based service model.
- Rep. Vander Woude inquired how much federal money was received by Arkansas to produce a $637 million savings over a seven-year period? Ms. Bachrach stated that she did not know at the moment but that such information was accessible to the public.

Co-chair Hagedorn thanked Ms. Bachrach for her knowledge and presentation and called for a 15-minute break.

At 11:00 a.m., Co-chair Hagedorn called Dr. Jim Brook to the podium for his comments to the committee. Dr. Brook shared his experiences at his Idaho Falls family practice where he traditionally sees patients considered in the "gap." He reported that his average fee for a visit was just $58 and that his collection rate for services last year was 101%. Dr. Brook felt that federal involvement over the years had caused the increase to healthcare expenses. He outlined his efforts to convince other providers and patients that the solution to these costs was to create free market practices. Dr. Brook cited the Surgery Center of Oklahoma as a successful center using the same methods that he

employed. He also commented on the need for dental offices to operate on this philosophy. Dr. Brook felt that many providers and patients did not know or were not aware of the possibility of healthcare without insurance being a key player. In truth, he reported that 54% of physicians did not use Medicaid because of their frustrations with the process and costs. Dr. Brook concluded that this method of healthcare may encourage others to seek out Idaho as a place of treatment.

- Co-chair Hagedorn asked whether more physicians did not embrace this model because payment often was made by a trade of goods for service? Dr. Brook restated that he collected 101% of his fees (due to patients tipping on top of the fee) because the fees were affordable. He admitted that only on rare occasions did he use a bartering of goods for service.
- Sen. Guthrie inquired whether Dr. Brook employed a method of screening patients for their ability to pay before agreeing to provide services? Dr. Brook replied that he did not screen potential patients; everyone was welcome to his services.
- Sen. Guthrie asked whether Dr. Brook had earlier suggested that the state steer employees to such a program, and whether Dr. Brook was aware that it would require an RFP (request for proposal) to do that? Dr. Brook could see the service being provided in such a manner; the employee could see the fee for the service in advance and decide if it was desirable. He noted that his clinic's fees were based on the amount of time spent with a patient, and not based on the procedures that he would perform, such as fee-for-service does. Sen. Thayn commented that Indiana offered an HSA and the ability to shop for the best price on services/procedures; such approach would circumvent the need for an RFP.
- Sen. Thayn inquired whether Dr. Brook dealt with patients who had chronic health diseases? Dr. Brook reported that he did have patients with chronic diseases and that most of such diagnoses were rather inexpensive to treat. For example, he offered that his patients with typical Type 2 diabetes, with high blood pressure and high cholesterol, could incur expenses of $250 to $300 per year, including lab fees. If he were also to supply medications, the patient would incur an additional $250 per year. He commented that this maintenance care, and his relationship with his patients, contributed to keeping his patients from more expensive treatments.
- Rep. Vander Woude queried how long Dr. Brook had been in practice, and whether malpractice insurance took a large portion of his profit? Dr. Brook responded that malpractice insurance was approximately $10,000 to $15,000 per year. He reported that he had been in practice for about 13 years; all on his own, except for the 3 months that he signed up to work with Medicare and insurance plans, which he promptly quit.
- Sen. Jordan asked how Dr. Brook dealt with patients diagnosed with needs for advanced care? Dr. Brook responded that he was trying to address such needs for his patients by getting free market advanced care centers here in Boise; but for the moment, his patients went to such places in Salt Lake City or consigned themselves to the centers here by using insurance programs.
- Sen. Jordan inquired whether Dr. Brook had health insurance for himself and his family? Dr. Brook responded that he did not have health insurance and that he accessed care through the free market. He commented that he did pay the shared responsibility fine since he opted out of insurance.
- Co-chair Hagedorn inquired whether Dr. Brook still had student loans to repay, and how was it possible for a physician to pay such loans while acquiring a facility and the expensive, yet necessary, equipment for his center? Dr. Brook acknowledged that he did have student loans yet to pay, but that he had some failures in establishing his practice that had set him back financially. Dr. Brook responded that it was possible to make it work, but it was a learning process that he was willing to share with others.
- Sen. Lodge asked Dr. Brook how large his practice was, and how was he able to acquire pharmaceuticals at such low prices? Dr. Brook shared that he received approximately 12-14 patients in a day. He also noted that he did not have such a large markup as most clinics on his

pharmaceuticals, so that his patients could afford the necessary medications. He explained that he purchased medications at wholesale or acquired generic brands, which were just as effective. He commented that he did not use free samples from pharmaceutical companies, as the intent was to encourage the purchase of their drugs.

- Sen. Lodge inquired where Dr. Brook went to medical college? Dr. Brook replied that he studied at Des Moines University.
- Rep. Chew requested that Dr. Brook compare the number of patients he served to that of another doctor in the traditional system. Dr. Brook reported that he probably did not see as many as other doctors, however, that alone provided a good market for other free market physicians. He noted that he did not employ a pre-screening nurse as he preferred to take the patient's initial information himself; if he had such a nurse, he could see more patients. Dr. Brook commented that a survey from California reported that 60% of doctors wanted to retire earlier, citing the hassles of healthcare bureaucracy as the reason. Additionally, physician assistants (not doctor level knowledge) were being hired more often by clinics to cover the load.
- Rep. Chew inquired what type of medications he prescribed for a diabetic? Dr. Brook responded that he prescribed the normal medications that were proven to work.
- Sen. Guthrie inquired how Dr. Brook's model would address the comprehensive needs of advanced and emergent care? Dr. Brook responded that he did not feel such high costs needed to be associated with those procedures, especially when clinics existed proving that they could operate just fine on reasonable costs. He was in favor of individuals acquiring catastrophic health insurance. He compared health insurance to vehicle insurance: individuals did not have insurance for gas refills or oil changes; it was for catastrophic damages.

Co-chair Hagedorn thanked Dr. Brook for his comments and encouraged him to continue his work inspiring others to provide care in such an accessible manner.

At 11:45 a.m., Scott Shurtleff, Operations Director for Project Access Northwest, joined the committee by phone for comments about his program operating in the state of Washington. Mr. Shurtleff explained that Project Access Northwest was a model project that began about ten years ago as a need to address underinsured and uninsured individuals. In studying the problem, it was observed that primary care was being addressed with community health centers, family care residences located within hospitals, and free and faith-based clinics, but individuals were not having their specialty care addressed. It was observed that the largest barrier for those seeking care was culturally related, such as language and traditions.

Project Access Northwest contracted with regional specialists to provide care under the pilot program. All referrals come from a primary care setting and participants complete an enrollment form. The program serves those who are at 200% FPL or below, on Medicare or Medicaid, and live in one of the counties being served (King County was the original for the pilot program). The program initially served those who were uninsured, yet it was the specialists who sought to expand the program to work also with Medicaid. Medicaid covers the interpreter costs that are needed. Funding for the program comes from hospital systems, foundation and corporate grants, private donors (3%), government and local grants through county agencies, events, and mailings. He noted that the work was very intensive, especially trying to keep communication between the patient, the primary care clinics, and the specialty care office, so staffing was always a challenge.

Mr. Shurtleff explained that since the program had launched before the ACA, providers expected that the ACA would fulfill the need that Project Access Northwest was providing, while others wanted Project Access Northwest to be the leader vetting the process to the providers and participants on the adoption of ACA. As the new participants came into the program, it was discovered that many had advanced care needs since illnesses had been undiagnosed for so long. Project Access Northwest has become the front door for Medicaid services for some of its providers, including

prior authorization for patients. The model was expanded to include patients being discharged who required follow-up primary care (Primary Link).

Mr. Shurtleff reported that Project Access Northwest had served 34,000 individuals and had 1,640 volunteer providers in 40 specialties serving three counties (King, Snohomish, Kitsap). The program expanded into dental care within the last couple of years, which included complex extractions, dentures, and dental clearances for those who need to be cleared for a transplant list. He added that dental providers were different than medical providers, as dentists were trained to be small business owners; hence, their contributions much more directly affected their profit. Mr. Shurtleff shared that he still had difficulties acquiring access to some specialties (such as rheumatology) and to durable medical equipment (such as C-PAP machines). He commented that a program needs strong advocacy and strong funding to be effective.

- Co-chair Hagedorn inquired how the expansion of Washington's Medicaid program affected the Project Access Northwest model? Mr. Shurtleff explained that the expansion helped, but that there were still individuals not covered because they did not qualify for the state's Medicaid for the following reasons: were undocumented aliens, did not met residency standards, moved and applied but were not instated yet in Medicaid, or had catastrophic coverage but still couldn't cover deductibles.
- Co-chair Hagedorn asked how the program handled situations when a patient needed an advance service, such as a CT scan? Mr. Shurtleff shared that the program had agreements with all of the hospitals and radiology departments that would void the cost of the services. He added that one provided nuclear medical treatment and there was no agreement; hence, a patient must pay or the patient would not receive the treatment.
- Rep. Vander Woude asked what percentage of patients needed the charity services? Mr. Shurtleff reported that the percentage was probably split at 60% on Medicaid and 40% that were uninsured.
- Rep. Vander Woude asked how difficult it was to find providers willing to offer charity services? Mr. Shurtleff explained that often a provider would limit the amount of time that the services would be offered, such as a one-year limit with the program.

Seeing no other questions, Mr. Shurtleff was thanked for his time and information. The committee then adjourned for lunch.

At 1:16 p.m., Co-chair Hagedorn reconvened the meeting and called upon Sen. Thayn for his presentation. Sen. Thayn felt that the current third-party payer system was the major reason that healthcare costs were so high. He promoted three ways to reduce the costs: funded HSAs, renewed focus on primary care, and changes to how primary care was funded. He promoted programs that put funds into the employees'/participants' hands so that they were more in control of their choices. He also proposed keeping programs independent of federal assistance, as much as possible, by using state appropriations.

- Co-chair Hagedorn inquired whether the $1,000 per person would be a block grant to the counties for establishing a program with sideboards? Sen. Thayn stated that he envisioned it would work that way.
- Rep. Vander Woude asked how limiting the amount of participants to 30,000 or 40,000 would help the 78,000 identified in the "gap" population? Sen. Thayn responded that the program was focused primarily on those with chronic health conditions. Rep. Vander Woude commented that it was earlier reported that 29,000 individuals of the 78,000 were permanently in the "gap" and suggested that a program focus additionally on that group. Sen. Thayn acknowledged the request.
- Sen. Guthrie asked whether it would be more effective to address those without chronic health issues, so that individuals didn't develop those conditions? Sen. Thayn felt it more necessary to address those with chronic health issues, so that they did not become emergent health issues, which would be even more costly.

- Sen. Guthrie inquired whether the proposed model would transition into a comprehensive care model and, if so, how would that transition help those in the "gap" population? Sen. Thayn responded that it was important to start with a solid foundation, and he felt this state-funded model was the best way to control the progress. He could see an option to partner with the federal government in the future by using a waiver to address hospital costs, but that he did not support a partnership with the federal government for primary care.
- Co-chair Hagedorn asked whether Sen. Thayn could forsee this as a managed care system, rather than just a primary care system? Sen. Thayn responded that he could see the program dovetailing into the program proposed by Director Armstrong (Dept. of Health and Welfare), however, this model worked from the bottom up.
- Co-chair Hagedorn inquired how those individuals in the "gap" could get assistance or counsel to use efficiently the allotted $1,000? Sen. Thayn explained that those individuals wouldn't qualify for an HSA because they did not have insurance, so the two ideas were not related. He did agree that eduction was a key part of any program.

Seeing no more questions, Co-chair Hagedorn called upon Sen. Jordan for her proposal and comments. Sen. Jordan proposed full Medicaid expansion to immediately and fully address the needs of those individuals in the "gap" who were currently not receiving any healthcare. Sen. Jordan commented that Idaho accepts federal funds for so many programs, yet still balked at accepting federal funds to help these individuals. In the meantime, these funds were being distributed to other states for use. She commented on the fact that once expanded, Idaho could make use of waivers to personalize and specialize its Medicaid program to better serve and represent Idahoans.

- Co-chair Hagedorn inquired whether Sen. Jordan was recommending Medicaid expansion, such as New Hampshire had done, where the program could be personalized with waivers as the delayed enactment approached? Sen. Jordan commented that New Hampshire's plan was a great example, as it solved the immediate need, but also allowed the state the time to study what programs were needed. She emphasized the need to get coverage for individuals while still having the flexibility to personalize Idaho's program. She added that Idaho had already created many effective programs and it would be possible to incorporate many of those program models/ideas into Medicaid expansion.

The committee members alternately provided comments for discussion:

- Sen. Thayn commented that anything other than full Medicaid expansion had to be launched before expanding Medicaid. He felt that Idaho should first test some of the ideas. He noted that there was no time limit on expanding Medicaid, and there was no "going back" once full expansion was put into place.
- Sen. Chew submitted that the state had gone too long in not providing coverage for individuals identified in the "gap." She felt that there was no time for experimenting. She commented that some of the ideas that had been discussed could be incorporated into the plan because they were good ideas, but something had to be done.
- Sen. Guthrie stated that the economic data was overwhelming and reminded the committee that the state already received approximately $1.8 billion for Medicaid. He felt that primary care was an important component of a managed care model, and that the state must have a nexus to comprehensive care. He also felt that any efforts should take advantage of the enhanced FMAP rate and that waivers should be employed, when possible, to make it Idaho's version of Medicaid. He supported the use of provider assessments in program models, the use of co-pays to help offset costs, and provisions in the plan for those unique ideas that may occur along the way.
- Rep. Wood commented that the committee needed to consider how the state would go forward with two different healthcare programs: one for the poor and one for everyone else. He felt that this would be unfair and unconscionable. His other concern was with the group within the 100-138% FPL, which was being funded by subsidies through the IRS; when fully expanded,

Medicaid money comes through the Medicaid side (in 2020) and the state begins subsidizing the funds for that group. Currently, all programs on the Idaho exchange were a fee-for-service model, increasing at 5-10% a year. He submitted that if the state expanded Medicaid, but kept the 100-138% FPL group separate, there would be huge costs to the state. Rep. Wood commented that all costs came from the delivery system, and there was no efficient way to change the system if 10-20% of individuals from outside the system were able to access the system at a moment's notice. He suggested that the state had to choose a comprehensive model that fit into the healthcare delivery system. In regard to the money going back to the states from the federal government: Idaho pays approximately 18 different types of healthcare taxes related to the ACA and receives none of those funds in return. Rep. Wood felt that at the very least, Idaho should be receiving its own tax dollars back to address healthcare efforts. He commented that he would support any proposal that employed the value-based service model, rather than the fee-for-service model. He proposed that monies already existing in other programs (the CAT Fund, the county indigent funds, Health and Welfare's expenditure in mental health and substance abuse, prisoner medical expenses, public health funds from the Tobacco Master Settlement fund, and the Millennium Fund) could be used for the effort to cover individuals. He theorized that funds from those programs would easily cover costs related to expanding Medicaid. He submitted that there were three ideal uses of waivers that the state should consider, if the state went down that road.

- Sen. Thayn reiterated that his stance on the use of federal money was economically driven, considering that the third-party payer system was costing the country $1.5 trillion.
- Co-chair Hagedorn asked how changing the insurance coverage for the 78,000 individuals, in comparison to those 1.5 million already covered, would affect the third-party payer system? Sen. Thayn commented that, traditionally, individuals on Medicaid went to the ER for treatment, which was costly; and expanding Medicaid didn't necessarily mean that healthcare would be provided. Additionally, individuals who have insurance often elect to have a higher deductible. He observed that the real root of the problem was the cost for both groups. He acknowledged that covering the 78,000 individuals in the "gap" was not going to change the system, it was just one part of the model's overall solution to healthcare.
- Co-chair Hagedorn commented that he liked Sen. Thayn's idea of HSAs for state employees, teachers, and other political subdivisions because it gave the state more leverage. But, he also believed that the solution to cover those 78,000 in the "gap" was not simply to expand Medicaid. He suggested moving such individuals into a primary care program, such as SHIP (State Healthcare Innovation Plan) for managed care. He felt that only providing primary care was not the solution as individuals were still needing specialist care.
- Sen. Thayn agreed that fee-for-service was not the way to continue and was more in favor of a membership or value-based model for primary care. As for comprehensive care, he felt that *where* the coverage started was the key to evaluating how well health issues were being addressed. He commented that his biggest concern was that overall healthcare costs could not be reduced within the structure of the current federal rules.
- Rep. Wood concurred that there was a need to move away from a third-party payer system because it only benefitted the provider and the consumer. He supported moving toward a value-based delivery system, which would make the healthcare system 100% financially responsible.
- Rep. Vander Woude shared that he sided with Sen. Thayn's theory in providing primary care for those in the "gap." He noted that the specialist care needs for those in the "gap" could be addressed with the charitable care model until a better idea was conceived. He also shared knowledge of a program that existed where doctors provided charitable care in exchange for educational credit. Rep. Vander Woude commented that there were enough great ideas on the table that Idaho could cobble together an effective model without yielding to fully expanded

Medicaid. He submitted that the realization of the federal government giving Idaho $500 million per year to save $50 million didn't seem a good return on the investment.

- Co-chair Hagedorn asked Rep. Vander Woude to explain how we can reconcile the fact that the state paid additional taxes for ACA but was not receiving any funds back. Rep. Vander Woude responded that Idaho was considered a "donor" state in that situation, but in an overall picture that Idaho was probably a donee state (i.e. transportation). Co-chair Hagedorn suggested that he ask the tax commission for a report on how much was paid in taxes to the federal government in comparison to how much was received.
- Sen. Jordan recognized that Idaho already had efforts in action that attempt to reduce healthcare costs and read into record the SOP of HB 260 [Ch. 164, 2011]. She submitted that the current efforts at meeting the directives of HB 260, combined with a full expansion of Medicaid, would put the state further along the path toward meeting the healthcare needs of the population.
- Co-chair Loertscher commented on how much money was being used to fix all the issues. His concerns included Rep. Wood's desire to usurp county indigent program funds when he would like to eliminate the program; and he saw it unfair to burden property tax payers with fees that the state was unwilling to provide. He noted that the state was already spending a large amount of funds on Medicaid and, hence, should not impose any requirements on the counties to fund the state's decision.
- Co-chair Loertscher asked Rep. Wood to explain what role the counties would play in his plan? Rep. Wood responded that Rep. Loertscher once had presented a bill that mostly eliminated the ability of the counties to levy an indigent tax. Additionally, the bill authorized the director of the Dept. of Health and Welfare to implement managed care using current state dollars and federal dollars that would be drawn down. He noted that the proposed bill essentially took the counties out of any obligation to provide healthcare since the state would, but the counties weren't in favor of the bill.
- Co-chair Loertscher commented that the issues driving medical care now were not the same issues at the time such bill was proposed. He felt that the least appropriate solution was full Medicaid expansion because it limited ideas that the state might wish to implement. He also acknowledged that expansion would probably cost more than was expected (history proved that things always cost more, never less) and that there were probably more participants than expected.
- Sen. Lodge reported that she had constituents share that they were spending $1500 per month and still had a $600 to $650 deductible. She submitted that the committee needed to consider Idaho's growth spurt with the influx of new residents, and reiterated her desire to include a component of accountability or responsibility in the proposed model.
- Rep. Boyle commented that she was not in favor of Medicaid expansion. She felt it was unfair to force folks onto Medicaid if it was not necessary. Rep. Boyle reminded the committee that the focus was to address the needs of those below 100% FPL.
- Co-chair Hagedorn summarized that it was the committee's charge to find a solution to control healthcare costs for all individuals while providing healthcare to those without it.

The committee decided that the next meeting would be held September 28 in Boise, with a focus on presenters who could provide solutions.

The meeting was adjourned at 2:55 p.m.