MINUTES
Approved by the Committee
Healthcare Alternatives for Citizens below 100 percent of Poverty Level
Wednesday, September 28, 2016
9:00 A.M.
State Capitol - Room WW17
Boise, Idaho

Co-chair Representative Loertscher called the meeting to order at 9:00 a.m.; a silent roll call was taken. Members present: Representatives Wood, Boyle, Vander Woude, and Chew; Co-chair Senator Hagedorn and Senators Lodge, Thayn, Guthrie, and Jordan; Legislative Services Offices staff: Elizabeth Bowen, Jared Tatro, and Ana Lara.

Other Attendees: Gregg Pfister – Foundation for Government Accountability; Lee Flinn – Idaho Primary Care Assoc.; Geoffrey Ward; Heidi Traylor – Terry Reilly Health Services; Fred Birnbaum, Dr. John Livingston – Idaho Freedom Foundation; Corey Surber – St. Alphonsus; Neva Santos – Idaho Academy of Family Physicians; Jim Baugh – DisAbility Rights Idaho; Toni Lawson – Idaho Hospital Assoc.; Bill Leake – Idaho Association of District Boards of Health; Geri Rackow – Eastern Idaho Public Health; Jerry Rienes, Lyn Moore – Idaho Independent Living Council; Russ Hendricks – Idaho Farm Bureau; Karleen Davis; Pat Day Hartwell; Shad Priest – Regence BlueShield of Idaho; Lisa Hettinger – Department of Health and Welfare; Brian Hadlock – Grand Peaks Medical and Dental; Gayle Wilde – American Association of University Women; Melissa Horsinger – Boise Physical Medicine and Rehabilitation Clinic; Paul M. Kalb; Charles Jordan; Luke Cavener – American Cancer Society Cancer Action Network; Mary Barinaga – family physician; Fran Collette; Bob Neugebauer – Gem State Patriot News; Donna Mitchell; Frank Monasterio, Mike Gallagher – St. Vincent de Paul; Reverend Sara La Wall – Boise Unitarian Universalist Fellowship; Michelle Gluch; Rich McBride, Betsy McBride – League of Women Voters of Idaho; Julia Smith; Tina DeBoer; Elwood Kleaver – Conex; Sharon Hawkins – Idaho Assoc. of Commerce & Industry; Tim Heinze – Valley Family Health Care; Judy Cross – Interfaith Alliance of Idaho; Carrie Foster – Lobby Idaho; 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 Loertscher called for a motion to approve the minutes of the August 29 meeting. Sen. Jordan made a motion, and Co-chair Loertscher called for a vote. Minutes were approved by voice vote.

Co-chair Loertscher invited Elizabeth Bowen, LSO Senior Legislative Research Analyst, to review the public comments/policy recommendations that she had received, and then to provide more details pertaining to the State Innovation Waivers. Ms. Bowen reported receipt of 216 public comments/policy recommendations since the last meeting: 98 emails, 1 letter, 5 phone calls, and 112 postcards. Of these, 17 supported Medicaid expansion or implementation of Medicaid expansion for a waiver; 117 supported nonspecific coverage for the "gap" population; and 72 opposed expansion of Medicaid. She added that no alternative solutions were proposed.

Referring to her handout, State Innovation Waivers, Ms. Bowen explained that an innovation waiver is permission from the federal government to waive certain requirements of the Affordable Care Act (ACA), and she added that this type of waiver will be available starting in January 2017. Continuing, she identified ACA provisions that can be waived, including the individual mandate, the employer mandate, and the health exchange. Ms. Bowen then broke down the requirements for a waiver program, and pointed out the states that have applied for the waivers, as well as those states considering application. Finally, she recounted ideas that other states have considered, such as:

- Single-payer systems (did not pass in Maine, Minnesota, and Vermont; on the ballot in Colorado).
- Allowing Medicaid-eligible individuals to opt out of Medicaid and purchase qualified health plans instead (did not pass in Minnesota).
- Working groups to study options available under these waivers, including alternatives to Medicaid (passed in Minnesota; did not pass in New Mexico).
- Waiving individual and employer mandates and establishing a system of affordable health insurance for state residents (passed in Ohio).

- Sen. Thayn asked for more details regarding the system created in Ohio. Ms. Bowen stated that Ohio passed a bill that authorized the director of the Department of Insurance to seek a state innovation waiver. The waiver would let Ohio waive the individual and employer mandates of the ACA. In its place, they would create a universal health insurance coverage in Ohio through some kind of state system, rather than by requiring employers to offer it.
- Following up, Sen. Thayn asked if the Ohio system includes the ten essential services mandated by the ACA? Ms. Bowen responded that under the guidance published by the Centers for Medicare and Medicaid Services, a waiver application would not be approved if it did not include all ten of the essential health benefits.

Co-chair Loertscher called upon Mr. Fred Birnbaum, Vice President, Idaho Freedom Foundation, for his presentation An Economically Viable Solution for the Gap Population. Mr. Birbaum emphasized that the question to be asked when considering Medicaid expansion is: "Is the solution viable and economically sustainable in the long term?" He recounted that when Medicaid was established, its purpose was to help the poor children and the disabled, not able-bodied adults. He added that Idaho's "gap" population of 78,000 consists of mostly able-bodied adults, and the majority do not have children. He then noted that by including able-bodied adults, if an economic downturn were to occur, more people will be affected with the expansion. Referring to Figure 5. and Figure 6., CBO Projections of ACA Medicaid Expansion Costs and Enrollment (slide #5 and #6), he stated that what we are seeing, when expansion gets going, is that the costs exceed original projections, including total costs and the costs per enrollee. Through calendar year 2016, there is a 100% federal match, so he emphasized that data from 2016 and earlier is not a guide to future program costs. Additionally, he noted that the enrollment projections keep going up.

Mr. Birnbaum stated that Medicaid expansion is the cornerstone of the failed Obamacare experiment (slide #8), and noted that healthcare spending was 18.2% of GDP in June 2016, compared to 13.3% in 2000. From this data, he calculated that the "gap" population can be covered with an incremental cost of $41,000 per person; and, he deduced it would have been easier to send them a check to buy insurance. Therefore, he suggested that the original premise of the ACA has not been met.

Mr. Birnbaum emphasized that the Medicaid expansion economics don't add up. Regarding the Medicaid expansion fiscal impact analysis based on the Milliman Client Reports (slide #11), he pointed to the truncated time frame from 10 to 5 years, and the addition of a multiplier. He stated that he is skeptical of the use of a multiplier, and he warned of the danger of becoming more dependent on a federal government that is very deeply in debt. He also provided data to reflect Idaho's dependency on D.C. dollars (slide #12). Additionally, he submitted the following data from the Milliman Client Reports related to the net cost to Idaho for Medicaid expansion (2021 to 2026):

- 90%-10% federal/state match rate: ($223 million)
- Projected at 70%-30% match rate: ($1.22 billion)

Mr. Birnbaum stated that it is not unreasonable to expect that the federal government will decide that 70%-30% is a pretty good match. If so, this expanded program will be competing for dollars with schools, public safety, and, potentially, the core Medicaid population. Also, if Idaho decides to opt out of the expansion program at some point, Mr. Birnbaum opined that this won't be a viable

option, given that federal statutes trump state statutes. He cautioned that choosing the waiver does not eliminate the issue of dependency on federal money, especially when the federal government is buried in debt. He then discussed the ramifications of CMS (Centers for Medicare & Medicaid Services) rejecting Ohio's cost-sharing Medicaid waiver request.

He provided the following proposed policy alternatives, adding that Dr. Livingston will propose additional policy alternatives during his presentation:

- Expand Individual Development Accounts under state law to include healthcare;
- Facilitate the partnering of non-profits, such as Project Access Northwest in King County, Washington, to provide doctors and premium support to those in need of primary and specialized medical care;
- Update state income tax form to allow direction of refunds to charity care;
- Consider using CAT (Catastrophic Health Care) and/or Millennium Fund to fund a transition to charity care.

Mr. Birnbaum added that his foundation's Policy Memo, distributed to the committee members at the August 29 meeting, provides details on each of the alternatives.

- Sen. Thayn asked if the initial "gap" number "underestimates" for Montana and other states was derived from use of a static model, and could Idaho's estimated "gap" number of 78,000 be really closer to 120,000? Mr. Birnbaum would look into whether there are any studies that focus on the reasons for the poor projections.
- Sen. Jordan asked if the data on healthcare spending as a percent of GDP from 1960 to 2016 (slide #8) is available adjusted for population increases, as well as for the baby boom population entering the system? Mr. Birnbaum stated that the chart reflects healthcare spending as a percentage of GDP - this is not in dollars. He stated that the GDP has grown because the population has grown. He added that he believes the data shows that healthcare spending as a percentage of GDP is growing.
- Sen. Jordan stated that multipliers are used in a variety of analyses, specifically with regard to tax cuts, and she asked why we would apply a different theory to the multiplier of these savings? Mr. Birnbaum stated there are different types of multipliers. He added that he was not suggesting that there would be no multiplier. Referring to Dr. Peterson's standard model, he opined one shouldn't rely on a multiplier that is based on federal money.
- Rep. Vander Woude asked if other states with the insurance exchange have been surprised by the increase in their "gap" population number (estimate number versus real number)? Mr. Birnbaum replied that 31 states have expanded Medicaid, and not all states have done state exchanges. He voiced his concern regarding the accuracy of the number 78,000 for the Idaho "gap" population because he does not know how it was derived. He recounted that, when asked what percent of the "gap" population have chronic medical conditions, Director Armstrong responded that he did not know.
- Referring to Mr. Birnbaum's statement that the original intent of the ACA was to bend the cost curve, Sen. Thayn asked if he could identify a state where Medicaid expansion bends the cost curve down? Mr. Birnbaum answered that when you take the total net costs over 10 years (slide #5) and divide by 110,000 (Milliman Report), the cost is $6,500 per person. He added that within the age range under discussion, which is the 19-64-year-old age band, he is not aware of any cost efficiencies.
- Co-chair Hagedorn asked what the "gap" population's motivation would be to choose a charitable option, like Washington's Project Access Northwest, over their present use of the emergency room. Mr. Birnbaum explained that, because Washington did expand Medicaid, Project Access Northwest helped with specialized medical services. If Washington had not expanded Medicaid, the results might have been that: 1) the niche specialized services provided by Project Access

Northwest would have been insufficient; or 2) Project Access Northwest would have been redirected to Primary Care.

- Co-chair Hagedorn then asked, if we become dependent on charity care, how can we effectively redirect the "gap" population from going to the emergency room, to going to the charitable organization? Mr. Birnbaum answered that data show that even with Medicaid expansion in place, the habits of the "gap" population haven't changed with regard to their use of emergency rooms. He stated that the policy alternatives he proposed can address the chronically ill population. He also suggested that it is important to encourage young people who are able-bodied to work full time and to pay for their insurance.
- Rep. Chew asked if he would comment on how he has assessed the cost of managing our present system versus the cost of managing with Medicaid expansion? Mr. Birnbaum responded that he believed the threat to the state by expanding Medicaid is greater than the benefit. He opined that a reduction in federal money will force trade-offs for the core Medicaid population, for schools, and for public safety. He emphasized that Medicaid expansion has not controlled costs under the ACA. With healthcare spending at 18.2% of the GDP, it is all being absorbed by the economy.
- Co-chair Hagedorn asked what is driving medical costs up as a portion of the GDP? Mr. Birnbaum responded that he believes answering that question would be useful, and he stated that he will research the issue and respond to the members at a future meeting.

Co-chair Loertscher called upon Dr. John Livingston, Special Advisor on Medical Policy, Idaho Freedom Foundation, for his presentation A Policy Solution for the "Gap" Population. Dr. Livingston stated his support for direct primary care (DPC), DPC when delivered by the private sector, and community health centers (such as Terry Reilly Health Services). And, he stated his opposition to top-down command and control healthcare delivery systems, the State Healthcare Innovation Plan (SHIP), and Medicaid expansion (though he voiced his support for Medicaid reform). He opined that by expanding Medicaid, we put the future healthcare of each person in the "gap" in jeopardy. Referring to the New Equilibrium Price chart (slide #10), he observed that, at present, the supply side of the equation is shrinking with the insurance carriers' networks and with the large provider systems at a time when demand has increased. He added that as aggregate supply goes down, and aggregate demand goes up, prices and costs go up.

Dr. Livingston expressed his concern for the SHIP system (slide #12). He opined that it is nothing more than a vertically integrated, top-down command economy housed in the Department of Health and Welfare. He questioned how it can operate and cut costs more than the free market system. Speaking to charity care in Idaho, Dr. Livingston mentioned several successful charity healthcare efforts, including the St. John's Free Clinic and the Love Caldwell Clinic. He advised the audience that, if they truly want to participate in providing care for people on the margin, they should volunteer their services to free clinics. He emphasized the government's role in taking care of those with chronic illnesses that live in the margins who, because of those illnesses, cannot work. As the costs of expansion increase, those are the people on the margin that will be most affected, and most discriminated against, when services have to be cut. His observations and suggestions included:

- Focus should be on securing long-term needs of those at the margin;
- Securing coverage is not the same as securing services;
- Coverage does not equal results;
- Cost before coverage, reform before expansion;
- Expanding access for 78,000 people at a time when we have a provider shortage risks covering 20,000 people most in need.

He recommended the following policy alternatives to the committee and to the Legislature:

- Review of governance documents, law, and malpractice reform;

- Target the estimated 20,000 people in the "gap" (based on Congressional Budget Office and Department of Labor data) who have chronic medical conditions;
- Utilize market-place solutions (LASIK, plastic surgery);
- Leverage existing healthcare providers (PAs, FNPs);
- Review existing state law to facilitate expansion of provider networks.

- Sen. Jordan asked if Dr. Livingston had Boise Mayor Dave Bieter's permission to use his image in the presentation? Dr. Livingston responded that he did not have permission. Following up, Sen. Jordan stated that Mayor Bieter has testified before the Health and Welfare Committee in full support of Medicaid expansion and in covering the healthcare "gap." Additionally, she objected to the use of the mayor's image in the presentation. Co-chair Loertscher commented that he did not believe Dr. Livingston said the mayor was not supporting Medicaid expansion. Dr. Livingston remarked that he did not have permission to use the article from the Associated Press, nor for using the clinic article from the various other charity organizations. He explained that he wasn't trying to state a position of Mayor Bieter, rather he was trying to demonstrate the Bieter family's contribution to charity care in Idaho.
- Concerning the cost of taking care of the 20,000 people in the "gap" that have chronic medical conditions, Sen. Thayn asked for more details about services that would be provided and what the costs might be? Dr. Livingston answered that he only has the number Mr. Birnbaum presented earlier - $6,500 to $7,000 for that group of people. Following up, Sen. Thayn stated his concern about applying a top-down approach to 1.6 million people in Idaho. Specifically, he described a scenario where hospital administrators and the Department of Health and Welfare decide how medicine is practiced, and the patients and the providers are taken out of the equation - thereby increasing the amount of paperwork that the providers have to give in order to make sure that they are following the administrators' recommended procedures on how medicine is practiced. Sen. Thayn stated that he is coming to the same conclusion that Dr. Livingston has come to, and he questioned how far down the road we want to go with this managed care approach.
- Sen. Guthrie commented that he agreed with much of what was in Dr. Livingston's presentation, and asked if he is okay with spending tax money to help the 20,000 people in the "gap" with chronic medical conditions? Dr. Livingston responded that he is in favor of spending tax money for the 20,000, with a caveat: He noted that, as the number of people in the "gap" is underestimated, the cost of services per person is overestimated. He stated that the most important thing to happen would be for the government to allow for situations where the regulatory environment on the provider side provides increased access, and the supply curve shifts back to the right, so the people can have access to the care they need without having to travel long distances. And, he also commented that multipliers work in narrow situations where the economy is being revved up, but it doesn't take into account the opportunity cost lost by that money being used in other places.

Co-chair Loertscher invited Corey Surber, Director of State Advocacy for St. Alphonsus, and Mr. Tim Heinze, CEO of Valley Family Health Care, to the podium for their presentation on behalf of the Close the Gap Coalition, Idaho's Roadmap to Healthcare Coverage. Ms. Surber noted that we are in need of a well-thought-out, complete solution to the coverage "gap," one crafted by Idahoans, for Idahoans. She added that her presentation would describe that solution to the members. Before she began her presentation, she responded to several claims made earlier in the meeting:

- Addressing the questioned validity of using five-year estimates, she stated that these estimates are the safest and the most accurate to use.
- Addressing the claim that the "gap" population is largely childless adults, she stated that over 60% of the "gap" population have at least one child at home.
- Addressing the concern that Idaho would be on the hook if the federal government decreases the match rate, she noted that several states have provisions that give

sideboards and protections. If the match rates are decreased, they can step away and not jeopardize the remainder of their Medicaid program.

- Regarding the risk of increasing the federal debt, she noted that the CBO (Congressional Budget Office) does indicate that closing the "gap" is reducing the federal debt.

Ms. Surber began her presentation by reviewing Idaho's coverage "gap" timeline, from 2012 (first Workgroup) to 2014 (Healthy Idaho Plan) and through 2015 (the beginning of the four-year pilot model), and she stated that after four years they have learned from other states, developed an understanding of gaps in access and delivery, and gathered data and research. Current opportunities she highlighted include:

- Develop a homegrown, Idaho-based solution;
- Integrate SHIP and primary care successes; and
- Realize savings and improved health outcomes.

Ms. Surber introduced Mr. Heinze to discuss primary care and SHIP integration. Mr. Heinze first described how primary providers in Idaho spend significant time and money trying to provide care that patients can afford. He stated that the coalition is trying to do something different, and that is what SHIP is about, and what practice transformation is about. He stated it is value- and outcome-based, providing improved health, improved healthcare, and lower costs. After reviewing the graph from Dr. Epperly's earlier presentation (slide #14), Mr. Heinze emphasized that closing the coverage "gap" will lead to greater primary care use and improved health outcomes.

Returning to the podium, Ms. Surber stated that the coalition's proposed solution includes the following components: essential coverage, utilization of federal and state dollars, managed care with SHIP integration, controlled costs, and the elimination of inefficient programs. She noted that this can be accomplished by emphasizing primary care, customizing a waiver, and incorporating legislative protections. Pointing to the Costs and Saving chart (Chart Book page 19/slide #21), she emphasized that the total fiscal impact of a full solution over the next five years is a net gain of $165.5 million. She added that the coalition's proposal is for a full solution that integrates lessons learned from SHIP into primary care.

- Co-chair Hagedorn asked if Ms. Surber was suggesting that SHIP be integrated just for the "gap" population, or integrated for all the Medicaid population? She responded that the Medicaid population would already be included in SHIP. The idea is that the "gap" population, once they have coverage, would have access to those medical homes through SHIP, whereas they may not have that access now.
- Following up, Co-chair Hagedorn commented that he thought "medical home" was the worst term we could have because it has negative connotations. He asked that this term be eliminated. Ms. Surber agreed that there has been a lot of confusion generated by the term, and then added that the term was coined by the American Academy of Pediatrics decades ago.
- Sen. Guthrie asked Mr. Heinze to explain the cost differences between the healthcare clinics he has been involved with in Idaho and Oregon? Mr. Heinze stated that he could not speak to cost differences; however, from a provider side and from a patient side, it is just easier to get patients cared for in Oregon.
- Sen. Thayn stated that his proposal, which has been characterized as a "primary care only" proposal, is really a "focus on primary care" proposal. He commented that he agrees with Ms. Surber's statement that a comprehensive solution is what's needed. However, he noted that there is a concern that Medicaid expansion is not the best comprehensive solution for Idaho. He identified two issues that need to be hammered out before we come up with the ideal solution: 1) the concern that the expansion doesn't reduce costs for everyone; and 2) that there is a basic disincentive to work with the expansion. Sen. Thayn asked what specific waivers the coalition is considering? Ms. Surber clarified that the coalition is not espousing Medicaid expansion, but

rather Idaho's alternative to Medicaid expansion. She stated that the 1115 Waiver has been used commonly by other states, and she offered to get more information on the various waivers or defer to the department to provide the information.

- Following up, Sen. Thayn asked Ms. Surber to clarify the terms "everyone in the same delivery system" and "payment reform." Ms. Surber responded that she does not interpret the SHIP model - the transformed delivery of care - as a top-down control approach. She stated it is about redefining the model for how the care is delivered at the patient level. It heavily relies on using IT to gather data to record the patient outcomes, so the providers can be accountable for those outcomes. In this manner, payment reform can hinge on how well those providers are managing their patients. She added that more of the payment models are moving to risked-based contracts, where providers understand they are moving away from fee-for-service, volume-based incentive toward pay-for-performance, value-based payment.
- Sen. Thayn asked whether gathering the data leads to the best treatment routines for certain diagnoses, or are we taking away the ability for the provider to make independent treatment plans? Mr. Heinze stated there isn't anything that dictates how providers practice medicine.
- Rep. Vander Woude remarked that both presenters are advocating adding 78,000 people to a plan where they said the reimbursement rate is too low, and he asked for an explanation on how this works financially for the doctors and the dentists, when the reimbursement rate is non-profitable? Ms. Surber responded that Medicaid payment rates change over time, and they are probably in a position to receive less "underpayment" now than we received prior to Obamacare. She added that receiving underpayment is better than no payment. She noted that the target at St. Alphonsus is to operate so they can run off of Medicare rates. With that, she stated that they advocate that the "gap" population get essential coverage, and we use the dollars available to reimburse for that care.
- Co-chair Hagedorn clarified that the members are trying to figure out how we are going to manage those Medicaid dollars most efficiently in Idaho. He added that mixing in general insurances would be a mistake for the committee to do. He suggested that this task force focus on: 1) what type of model we are going to build that will be an Idaho model, and 2) where we are going to set our sideboards. He suggested the task force could present this to the Legislature, and then be in a position to hand something to Health and Welfare.

Co-chair Loertscher called upon Mr. Gregg Pfister, Legislative Relations Director, Foundation for Government Accountability (FGA), for his presentation An Overview of Obamacare's Medicaid Expansion and Idaho's Most Vulnerable Citizens. Mr. Pfister stated that the FGA has been involved with the Medicaid expansion debate in more than two dozen states. He defined Medicaid expansion as an optional, inclusionary category of eligibility to a new group of people - adults without disabilities, who are 19-64 years old, without a full-time job, and with an income at 138% or less of the FPL. He added that most have no children at home. He remarked that the "gap" population needs work, not welfare, and observed that working 31 hours a week would qualify most for some form of federal subsidy. He recounted the unpredicted costs of Medicaid expansion in Washington, Ohio, Illinois, Alaska, and Kentucky (slide #4), and further explained that the FGA has reviewed every state that has made its predictions available. He noted that every state surpassed the maximum number it thought would be eligible by an average of 71%. He opined that extending Medicaid to people who already have insurance is a significant problem, and he discussed the reasons the state of Maine, a state that had expanded Medicaid in 2002, reversed its course. He recounted that by saying no to expansion, Maine has been able to say yes to things that actually help the people who truly need it and still have money for other budget priorities. Mr. Pfister noted Medicaid expansion's track record in other states: prioritizing able-bodied adults over its most vulnerable citizens, creating uncontrollable costs, eliminating budget flexibility, and crowding out priorities. He added that expansion will also help direct people with insurance onto Medicaid, and put the truly needy at risk. He concluded that the solution for the so-called "gap" population is work, not welfare.

- Sen. Jordan stated that "gap" population data the committee has seen show that about two-thirds of those 78,000 people are in homes with at least one full-time working person. Additionally, several studies reflect that the Idaho minimum wage does not sustain even the most modest housing units and that child care expenses are almost equal that of college. She remarked that his data was different, and asked if he would identify his sources? Mr. Pfister answered that he presented national data. He stated that when discussing "children who live in home" and "adults that have children in their house," whether or not they are children or adult children, if an individual is working a full-time job at minimum wage, then they will be earning enough to qualify for those federal health insurance subsidies. He stated that children, and individuals that are at need, are on that increased percentage scale for qualification - it would be the adult who would not qualify. He opined that the solution to that is a good-paying job.
- Sen. Guthrie asked for clarification regarding cost overruns presented in slide #4, was he speaking to expenditures of federal dollars beyond what was projected? Mr. Pfister responded that the data reflect the total overrun beyond what was projected for the entirety of the program; so, just what the program was going to cost, regardless of what the federal or state rate would be. Co-chair Loertscher asked if he was speaking about strictly federal dollars or both federal and state dollars? Mr. Pfister stated he was speaking about federal dollars. Following up, Sen. Guthrie asked if he was talking about all of Medicaid, not just the expanded piece? Mr. Pfister stated he was speaking about the expansion program.
- Following up, Sen. Thayn asked if Mr. Pfister intended to say that the reason more people than expected sign up in all these states was because expansion changed their behavior? Also, he asked if there is data that captures what percent of the overrun is the population that moved to Medicaid from private insurance? Answering the first question, Mr. Pfister stated that it is a constantly fluctuating number. When expansion goes through, individuals who qualify for federal subsidies can contribute money toward an insurance plan or go into Medicaid. Responding to the second question, the number of people who had insurance went down, but the number of people who remained uninsured did not change, so those people went into the program.
- Rep. Chew asked Mr. Pfister if he could point to any savings for those states that expanded (slide #4)? Mr. Pfister stated that the hospitals in Arkansas reported savings of $60 million a year because of expansion. He noted that to achieve the savings, there was an expenditure of over $2 billion annually. Rep. Chew then asked if he would discuss what some states are suggesting are the benefits of Medicaid expansion? He stated that the suggested benefits often do not come true; for example, the suggestion that with expansion there would be an influx of jobs. He emphasized that expansion is not a solution, and it is putting people at risk.

Co-chair Loertscher invited Mr. James Baugh, Executive Director of DisAbility Rights Idaho, to the podium for his presentation on behalf of the Consortium for Idahoans with Disabilities, Medicaid Expansion/Reform and Idahoans with Disabilities. Mr. Baugh began by responding to comments made by earlier presenters:

- He noted that both Mr. Birnbaum and Dr. Livingston mentioned that, according to CBO figures, there were 20,000 Idahoans with chronic health conditions who were probably in the insurance gap, and they acknowledged that it would be a legitimate use of taxpayer money to cover those people. Mr. Baugh stated that he believes that number is more than 20,000.
- He stated that the Foundation for Government Accountability does not have a constituency that includes a significant amount of people with disabilities, and the foundation does not speak for Idahoans with disabilities.
- He stated that Medicaid expansion is not the reason for waiting lists for waiver services, and in Idaho there are no waiting lists for the Medicaid 1915(c) Waiver. He stated he wishes to preserve Idaho's "waiting list-less" waivers.

- He encouraged the members to review the memorandum, presented by Ms. Lauren Necochea at the committee's August 29 meeting, that compares states that have expanded with states that have not expanded, in terms of savings.

Presenting on behalf of the consortium, Mr. Baugh suggested that the best plan for Idahoans with disabilities that are in the insurance "gap" would be for the state to adopt straightforward Medicaid expansion, as well as some measure of reform, noting that a 1950(b) Waiver or a 1115 Waiver could get this done. He detailed the changes that are necessary and indicated his proposal takes the state Catastrophic Health Fund patients, the county indigent patients, and most of the state mental health patients, and moves them into Medicaid. The result is an integrated managed care plan that will serve their needs. He identified Idaho's three Medicaid plans (basic, enhanced, and coordinated). He emphasized that a basic healthcare plan is not the same as Medicaid coverage for people with disabilities - an enhanced plan is required, and it does not look like an average health insurance that might be purchased on the exchange.

Mr. Baugh identified those Idahoans with disabilities who are not covered, as well as those with serious mental illness. He stated that of the 48,000 Idahoans with serious and persistent mental illness, approximately 27,000 receive treatment through the Department of Health and Welfare, and only 14,000 are currently covered by Medicaid. He submitted that 13,000 of the 48,000 get services through the Division of Behavioral Health and are in the "gap" population. Some of the remaining 21,000 have Medicare, some are in jail, and some are in the "gap." Mr. Baugh highlighted the following points related to fixing the mental health system:

- Idaho's current mental health system is in crisis and does not meet the needs of Idahoans with serious mental illness.
- Medicaid expansion/reform would provide a range of community-based mental health services to nearly all Idahoans with a serious and persistent mental illness.
- Medicaid expansion/reform could fix much of what is wrong with Idaho's current mental health system using federal dollars.
- The estimated total Behavioral Health General Funds Savings through adopting expansion/reform would be $10.25 million per year.

Mr. Baugh emphasized that people with disabilities often need long-term home and community-based supports to avoid costly institutionalization and acute medical care. Medicaid provides these services with an administrative cost of only 3% versus 15-20% in exchange plans. He suggested that one alternative to expansion that might provide the needed care for people with disabilities is the creation of a hybrid system, one where people with disabilities would be "carved in" to the Medicaid system, while providing exchange policy coverage to other people over 100% of FPL. He warned that this solution would add unnecessary complexity, cost, and bureaucracy. He concluded that the committee should consider just expanding Medicaid under the ACA for people with disabilities, as it is the simplest, most effective remedy.

Public Testimony. Co-chair Loertscher encouraged those testifying to assist the committee by suggesting solutions that they believe will work for Idaho. He explained names would be called in the order they appear on the sign-up sheet. A total of 35 people testified to the committee: 34 testified in favor of providing a comprehensive healthcare coverage plan for the "gap" population and/or Medicaid expansion, and one testified against Medicaid expansion. Five people testified on behalf of an organization. A list of all those who testified in person can be accessed via this link, Public Testimony, and also can be viewed at the committee's home page, within the Idaho Legislature's website.

At the conclusion of the public testimony, Co-chair Loertscher thanked all the individuals who testified. The committee decided that the next meeting would be held Monday, October 24, in Boise.

- Noting similarities between New Hampshire and Idaho on several of the issues the committee must address, Sen. Jordan stated that she will get New Hampshire's recent legislation, and asked Ms. Bowen to distribute it to the members. She also suggested the committee would benefit from a phone conversation with New Hampshire's Medicaid director at the meeting on the 24th. Co-chair Loertscher agreed that it would be wise to have that conversation.
- Sen. Thayn noted that Co-chair Hagedorn had mentioned some sideboards members had suggested, and he remarked that it would helpful to discuss them.
- Rep. Boyle asked if Ms. Bowen would invite someone who could speak to the committee on the state innovation waiver. Ms. Bowen responded that NCSL could probably recommend a speaker, and she agreed to contact them.
- Sen. Guthrie stated a key decision that has to be made is whether we intend to access the enhanced FMAP rate. He emphasized that it should be on the front end of the decision-making.
- Co-chair Loertscher suggested the committee address whether it is possible to have a hybrid system, and added that Sen. Guthrie might cover this at the next meeting.
- Co-chair Hagedorn commented that he didn't see all the members agreeing on a bill, but suggested the members might be able to agree on a joint resolution - one that would state what the issues are and what the potential solutions could be. Co-chair Loertscher agreed with Co-chair Hagedorn, stating that the resolution might be the best way to go with regard to making recommendations.
- Co-chair Loertscher stated that his take-home assignment for the members was for them to put their ideas down on paper and to bring their proposed "in a perfect world" solutions to the next meeting. Ms. Bowen noted that the committee has the option of putting together a final report, which she volunteered to draft. She added that both recommendations and draft legislation can go in this report.

The meeting was adjourned at 4:32 p.m.