Beautiful - and water-wise plants; and, composting pea vines can be trouble **5C**

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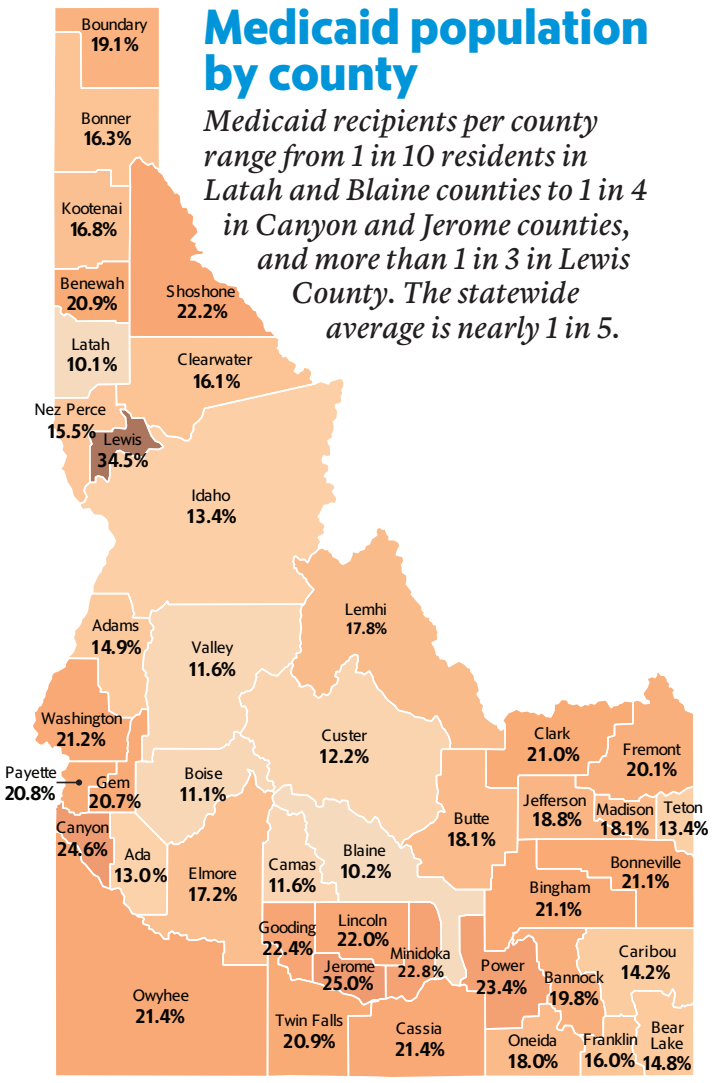
Depth

OPINION

AS DALLAS PROVES, THE SKY WON'T STOP FALLING ON US, WRITES ROBERT EHLERT **2C**

Medicaid population by county

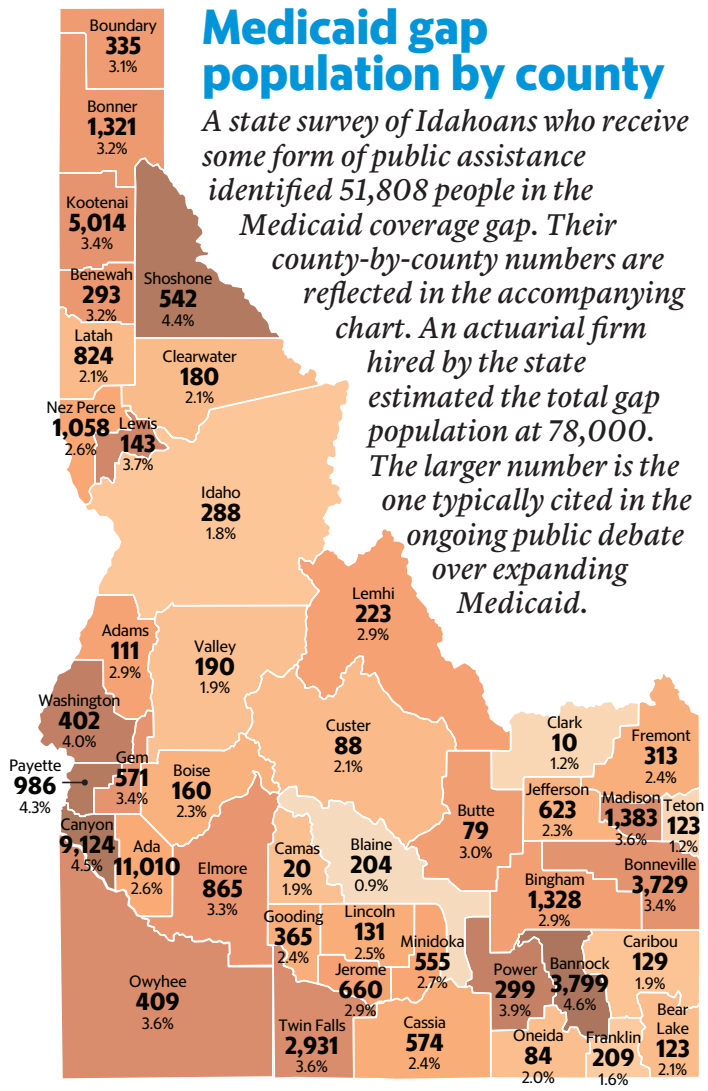
Medicaid recipients per county range from 1 in 10 residents in Latah and Blaine counties to 1 in 4 in Canyon and Jerome counties, and more than 1 in 3 in Lewis County. The statewide average is nearly 1 in 5.



Source: Idaho Department of Health and Welfare

Medicaid gap population by county

A state survey of Idahoans who receive some form of public assistance identified 51,808 people in the Medicaid coverage gap. Their county-by-county numbers are reflected in the accompanying chart. An actuarial firm hired by the state estimated the total gap population at 78,000. The larger number is the one typically cited in the ongoing public debate over expanding Medicaid.



Source: Idaho Department of Health and Welfare

> **IT REALLY GOES TO THE QUESTION OF WHAT KIND OF SOCIETY DOES IDAHO WANT TO HAVE.**
>
> ***Dr. Andrew Baron, chief medical officer, Terry Reilly Health Services***

MEDICAID EXPANSION

8 myths about covering the uninsured in Idaho

Legislature, which rejected expansion this year, takes up another review this summer

Repeatedly recommended for Idaho, but misconceptions on viability, effectiveness persist

Lawmakers have promised action in 2017

BY BILL DENTZER
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Sometime this summer, a committee of lawmakers will start to sort out what a wary Legislature might find palatable by way of accepting billions in federal funding to help thousands of Idahoans who have thus far lost out on the promise of better, affordable health care envisioned under the 2010 Affordable Care Act.

Idaho is the only Republican-controlled state that saw the economic advantage in creating its own health exchange. Three years on, Your Health Idaho ranks among the most successful in the nation in terms of enrollment, service delivery and cost control.

But die-hard opposition to Medicaid expansion makes it Idaho's last unfinished piece of ACA business. The ad hoc panel has yet to schedule its first meeting, but when it convenes this summer, on the agenda will be how, or whether, to subsidize health coverage for a population whose meager incomes land them in a Catch-22, earning too little to apply for subsidized insurance on the state exchange but too much to qualify for standard Medicaid.

The panel will rake over the ashes of the plan that died in the final hour of the 2016 session in March, when the House balked at a Senate bill to move expansion forward. If it had passed, state officials would be working with the feds on a state-managed program to administer the estimated $7.5 billion in additional federal aid Idaho stands to receive in 10 years of expanded Medicaid.

It's not just a matter of dollars.

"It's a much broader question," said Dr. Andrew Baron, chief medical officer for Terry Reilly Health Services, whose 16 clinics in Ada, Canyon and Owyhee counties cared for 30,000 patients last year, 58 percent of them uninsured and 70 percent below the federal poverty level. The caseload has ticked up by 500 people since April.

"Do we want to disregard those that are poor, or do we feel that we should be helping them, and I believe that we should absolutely be helping them with Medicaid expansion," Baron said.

Lawmakers already have weighed in on the subject. The Legislature was represented on two governor-appointed work groups that, in 2012 and 2014, each endorsed a custom, Idaho-managed expansion option. Nothing much has changed since, although several more Republican-controlled states have opted for and created their own customized expansion plans. Gov. Butch Otter could negotiate a plan with the federal government but has declined to do so without official legislative buy-in.

The new panel does provide a forum for fence-sitting or opposing lawmakers either to get comfortable with expansion or sharpen their talking points against it. Mostly, though, the group will be covering well-plowed ground.

What follows are Medicaid expansion myths, misunderstandings and misconceptions that might surface in their discussions.

2
Number of governor-appointed work groups that have studied Medicaid expansion and recommended adoption

$2 BILLION
Cumulative economic impact, in higher sales, output and compensation, generated by $600 million infusion of Medicaid dollars

> **THEY WON'T GO IN WHEN THEY'RE FIRST SICK. THEY WON'T GO IN WHEN THEY START TO BECOME VERY SICK. THEY'LL ONLY GO IN WHEN THEY HAVE NO CHOICE.**
>
> ***Yvonne Ketchum-Ward, CEO, Idaho Primary Care Association, on health care choices faced by gap population***

1. WE CAN'T AFFORD IT.

Whether the U.S. ought to fund entitlements such as Medicaid is a philosophical question, not a financial one. Health care costs have risen more slowly since the ACA went into effect, the slowest in 55 years. The argument that the deficit will choke the nation is often cited by advocates of smaller government or those opposed to entitlements. But health care reform has reined in rising costs, not contributed to them.

SEE MEDICAID, 3C

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MEDICAID

In Idaho, advocates argue that the state can't afford *not* to expand Medicaid in some fashion. The current system costs more because it is inefficient and because it is entirely state-funded through taxes. Costs of indigent care that providers end up writing off mean rates and premiums go up to offset losses. Lost productivity is greater with a lesser standard of care, with ripples through the economy.

For the fiscal year beginning next July, expansion would represent about a $600 million infusion of new cash into the state economy, creating jobs, spurring investment and sales, and boosting tax revenue, not to mention improving health for tens of thousands of Idahoans and reducing lost productivity. The University of Idaho has calculated the economic impact of that windfall, in terms of increased sales, output and compensation, at more than triple the federal cash — nearly $2 billion, with another $38 million more collected in taxes.

Turning down Medicaid expansion dollars means Idahoans are rejecting funds they have already paid into the health care system via their taxes. Idaho is effectively subsidizing other states that have expanded Medicaid. With expansion, the state's health care costs for the uninsured would drop by 20 percent the first year, from $57.7 million to $45.4 million, with a better standard of care.

Idaho could have saved nearly $100 million more if it had opted for expansion two years sooner. Over time, the savings flatten out, and in the long run the state outlay will be higher, but with offsetting benefits. Through 2026, the cumulative cost to the state is forecast at $812 million. Maintaining the status quo would cost $594 million, $218 million less. But the gap group would still lack health coverage; the care they do obtain would remain inefficient, its costs borne by the state; and Idaho's economy would be billions of dollars poorer.

"From a dollars to dollars comparison, yes, there are increased costs," said Brian Whitlock, president and CEO of the Idaho Hospital Association. "But with that come increased benefits, and that is a reduction in property tax, a reduction in the amount of state general funds that go to the catastrophic health care, and in return you get an infusion of hundreds of millions of dollars back into the economy from the matched Medicaid dollars."

2. MEDICAID IS BROKEN AND IDAHO SHOULDN'T EXPAND IT

If you oppose entitlement programs in general, then you won't be swayed by the argument that Idaho's Medicaid premiums have grown slower than commercial rates — 5 to 10 percent slower since 2011. Its program is one of the leanest in the nation. Its expansion plan would be unique, and different from standard expansion. The state would seek permission from the federal government for options that could include copays and other requirements for participants.

Since 2014, the state quietly has been reinventing how Idaho delivers health care. With the help of a $40 million, four-year federal grant, it is moving away from the traditional fee-for-service model that drives higher costs, and toward a better-coordinated, holistic approach that delivers better care at lower cost.

TWO-THIRDS OF PEOPLE IN THE GAP WORK IN LOW-WAGE JOBS, 55 PERCENT ARE WOMEN AND 65 PERCENT HAVE AT LEAST ONE CHILD AT HOME.

3. THE GAP POPULATION IS MADE UP OF ABLE-BODIED ADULTS WHO SHOULD BE WORKING

They are working. Two-thirds of gap households have earned income. They work in food service, construction, agriculture, home health care, child care, retail sales, transportation, office and admin support, and in janitorial services. About 12 percent have income from social security, child support or a pension.

Even with jobs they still make less than 100 percent of the federal poverty level and are not eligible to buy subsidized insurance on the state's health exchange. And they earn too much to be eligible for traditional Medicaid. Some other statistics:

- 55 percent are female.
- 84 percent are 18-50 years old.
- 65 percent of gap households have at least one child at home. The child is on Medicaid, the parents are in the gap.
- 25 percent are single-person households and 58 percent have three or more.

4. WHERE DID THIS 78,000 FIGURE COME FROM ANYWAY?

Milliman, an actuarial firm working for the state, arrived at that number based on census and demographic data. A January 2016 update to its original findings puts the gap population at 78,581. Separately, the Department of Health of Welfare last year looked at Idahoans currently receiving public assistance in some form and identified 51,808 people who would receive benefits under expansion. Whatever the actual difference, it represents a population that now receives no other benefits or assistance.

5. IT'S NOT AN ISSUE WHERE I LIVE

Based on the IDHW headcount cited above, there are people in the gap in every county in the state. Their numbers are highest in southwest and eastern Idaho and range statewide from under 1 percent to 4.6 percent of county population. The counties with the highest rates are Bannock, Canyon and Shoshone. The largest gap populations are found in Ada, Canyon and Kootenai.

LEGISLATIVE DISTRICTS 10, 11, AND 12 IN CANYON COUNTY, DISTRICT 25 IN TWIN FALLS COUNTY, AND DISTRICT 28 NEAR POCATELLO HAVE THE HIGHEST GAP POPULATIONS.

6. THE GAP POPULATION HAS ACCESS TO HEALTH CARE ALREADY

The care they receive is minimal — until an expensive emergency occurs. The state's community health centers report that low-income people seek care only when they are really sick or injured. There is no provision for preventive care or a long-term treatment, no management of chronic conditions, no coordination to guide follow-up care.

People in poverty suffer a higher prevalence of chronic diseases, a sign of substandard or delayed medical care. They are twice as likely to suffer from depression; half again as likely to have asthma, diabetes or suffer a heart attack; 25 percent more likely to be obese; and 10 percent more likely to have high blood pressure.

In describing their plight, Yvonne Ketchum-Ward, CEO of the Idaho Primary Care Association, tells people to put themselves in the position of someone who's uninsured, struggling to cover rent and the food budget, "and then they start not to feel well."

They might know they can go to a clinic for primary care of a specific condition at sliding-scale cost, she said, but they put off treatment when the cause of their ailment is unknown, and with it, the cost to treat it.

What's more, there's a limit to what a clinic can treat.

"If you do find out that you've torn your meniscus in your knee and you need surgery to fix it, that can't be done in one of our clinics," Ketchum-Ward said. "And if you don't have the money to pay for it, you usually don't have the money to manage the pain, and it causes you not to function as well. Maybe you can't work as well. It's a vicious cycle."

7. THESE ARE LONG-TERM WELFARE RECIPIENTS

IDHW looked at six years of data on enrollments for food stamps, now known as SNAP, from the peak of the Great Recession to present. Of 575,000 enrollees in that period:

- 75 percent, or 431,000, cycled on and off assistance one or two times due to a temporary crisis, most commonly a job loss.
- 16 percent, or 92,000, cycled on and off three or more times. Typically, these were people with seasonal or fluctuating incomes who were right at the margin for income eligibility.
- 5 percent, or 28,750, were on assistance for an extended period. Typically, these were people in their 50s who lost employment.
- 4 percent, or 23,000, received assistance continuously for all six years. Of those, almost half were disabled or had a disabled person in the household; 32 percent were single moms; 27 percent were seniors; and 37 percent were two-parent households with kids. Of the last group, 92 percent had earned income.
- For the entire population, the average length of time on food stamps was 13 months.

8. IDAHO DOESN'T HAVE ENOUGH DOCTORS

Susie Pouliot, CEO of the Idaho Medical Association, often hears this.

"What I typically say is, even if we didn't have enough doctors, is that a reason to deny health care?" she said. "No, it's not."

Pouliot noted efforts to broaden the pipeline, from new and expanded training programs to loan repayment and recruiting incentives to attract more physicians. The federally-funded SHIP program, in which health care professionals work in teams to address the range of patient's needs, "can take better care of patients and take care of more patients than just a physician working in a traditional model," she said.

"Yes there will be an initial surge of people seeking access because they have had unmet health care needs for a long time," she said. "But that evens out over time."

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