MINUTES
Approved by the Committee
State Employee Group Insurance & Benefits Committee
Friday, October 07, 2016
9:00 A.M.
Room EW42
Boise, Idaho

Co-chair Senator Todd Lakey called the meeting to order at 9:03 a.m.; a silent roll call was taken. Committee members in attendance: Co-chair Senator Todd Lakey and Co-chair Representative Fred Wood; Senators Dan Johnson, Robert Nonini, Jim Patrick, and Dan Schmidt; Representatives Neil Anderson, Robert Anderst, Jason Monks, and Hy Kloc. Legislative Services Office staff present were: Kristin Ford, Robyn Lockett, and Ana Lara.

Other attendees: Jennifer Pike, Dept. of Administration; Scott Kreiling and Shad Priest, Regence Blue Shield of Idaho; Sean Karbowicz, MedSavvy; Aleasha Eberly, Simplot; Tim Olson, Norm Varin and Josh Bishop, Pacific Source; Dave Jeppesen and Kelly Carew, Blue Cross of Idaho; Doug Toschi, Propel Insurance; Josh Sears, Helbling Benefits Consulting; Heather Reynolds and Susan Buxton, Dept. of Human Resources; and Carlie Foster, Lobby Idaho.

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

Co-chair Lakey called for approval of the minutes from September 1, 2016. Co-chair Wood made a motion to approve the minutes. Representative Anderst seconded the motion. The motion passed unanimously.

Regence Blue Shield of Idaho Plans - Mr. Scott Kreiling

Co-chair Lakey called upon Mr. Scott Kreiling, Plan President for Regence Blue Shield, and Mr. Sean Karbowicz, Lead Pharmacist for MedSavvy, to begin their presentation. Mr. Scott Kreiling explained that during his presentation he would:

- Introduce Regence BlueShield of Idaho;
- Share an employer perspective and a healthcare vision of the future;
- Share experiences of shifting from fee-for-service to value-based provider/hospital reimbursements; and
- Discuss state of the art in transparency and consumer engagement tools.

Highlights and additional facts for Ms. Kreiling's presentation included:

- Regence Blue Shield of Idaho is a not-for-profit company that is headquartered in Idaho.
- Regence Blue Shield also has an affiliation with Cambia Health Solutions that is in Washington, Utah, and Oregon. Cambia Health Solutions, as an employer, has 4,600 employees.
- 12 years ago Regence Blue Shield began working on their health plan to address a sedentary work-force and impact their lives. They kept health plans available to their employees and introduced a health savings account (HSA).
- There are not many consumer tools available and there is lack of understanding regarding healthcare decisions. Regence began creating and investing in tools (e.g., MedSavvy) for their employees.
- Over a period of the last 5 years, $5 million has been saved among medical costs, absenteeism, and disability claims. There has been an average increase of approximately 5% on rates each year. Their goal is to make health insurance easier to understand and affordable.
- Factors for value-based reimbursement include:
    - Encourages collaboration with physicians and hospitals;
    - Provides data and supporting analytics to providers;

    - Ties reimbursement to quality improvement; and
    - Lowers the cost of care by shifting focus from the quantity of care to the quality of care.
- Total cost of care program includes: working with clinics and physicians to share and analyze data, finding agreement on cost trends and quality targets, and having shared savings payout tied to quality performance (gain-share only).
- 3-year program for pay-for-performance targets:
    - Year 1: minimum increase, agree on improvement target;
    - Years 2 and 3: increase tied to quality improvement;
    - Meeting or exceeding target results in increased reimbursement; and
    - Mitigate cost-shifting to commercial payers from CMS losses.
- Benefits of value-based reimbursement include:
    - Prepares Idaho providers for federal requirements coming in 2018;
    - Rewards quality improvement;
    - Distinctly different emphasis on quality versus simply the quantity of care; and
    - Brings an added measure of cost stability.
- Healthsparq is an employee engagement tool company that was invested in by Cambia and it is currently impacting 74 million lives. HealthSparq Magnify is looking at ways to improve consumer awareness and access to drive higher engagement rates and lower healthcare spending.
- In a consumer awareness for health engagement tools survey last year, 78% would have done something different had they known the price of care in advance.
- Medical and pharmacy are on the same platform and there is full integration as a carrier. The benefit of this is that analytics can be run on the entire population and claims tied to those employees, both medical and pharmacy, and partner with employers looking for targeted campaigns.
- Pharmacy cost is a major issue. Some pharmacy drugs fall under the medical plan. Regence's pharmacy program analyzes the medical and pharmacy costs in an effort to create solutions to help control costs.
- Speciality drugs are expected to account for 50% of drugs in 2018. Specialty drugs accounted for 22% of drugs in 2014.
- Common Plan Design is a 3-tier pharmacy drug plan design that includes: generic, preferred brand, and non-preferred brand. The Smart Choice Design is a 6-tier program include: preferred generic, non-preferred generic, preferred brand, non-preferred brand, preferred specialty, and non-preferred specialty. This second design provides employers a second drug design option.
- MedSavvy is a resource that is available to members and their doctors to assist them in making good decisions regarding their medicine. They work with providers to be a partner and offer transparency.
- People who are caregivers or have chronic diseases are more likely to do research about their medications.
- A quarter of patients will not fill a prescription due to cost. About half of patients taking medications for a chronic illness will stop after 90 days, and cost may be one of those reasons.
- MedSavvy is working to provide information costs and quality of prescription drugs and choice to both the physician and patient. They want to arm the patient with clinical information about the prescription drug.
- MedSavvy gives patients and doctors easy access to medication options, effectiveness results, prices, and personal experiences to help them find the best treatment at the best cost.
- The specialized pharmacy team reviews available evidence on how well medications work, how good the science is for that research, and assigns each drug an evidence grade that can be used to easily compare treatment options.
- MedSavvy has a grading system for treatments based on evidence-based assessments that drive their formulary.

Discussion:

Co-chair Wood asked if the presenters could explain how pharmacy coupons affect costs and potentially their proposed 6-tier pharmacy design plan. Mr. Karbowicz explained that Regence and Cambia support methods that can lower costs for patients to make medications more accessible. However, coupons only apply to a portion of the cost of the drug, and it is typically the member's share. A manufacturer sponsored coupon will hide the cost of the medication and lowers the out-of-pocket cost of the prescription that the benefit was designed for. Med-Savvy will be working on how to coordinate better the availability of coupons with the prescription benefits.

Co-chair Wood asked if Mr. Karbowicz could explain to the committee how a drug coupon program works and how that has the potential to affect the price the carrier pays. Sean explained that a brand named manufacturer will make available a coupon and the manufacturer essentially covers the co-payment. The manufacturer may raise prices over time in order to cover those rebates.

Representative Anderson asked what quality improvement is, how it is measured, and how one coordinates reimbursement. Mr. Kreiling explained that for physicians, it is accomplished through jointly meeting with them and looking at the membership in the geographic area to understand the underlying conditions in the area, and setting quality metrics based on national standards that are measurable. If physicians can improve the health of the population and lower costs, Regence will share some of those savings with physicians.

Senator Schmidt asked about what the premium increase for employees year-by-year. Mr. Kreiling responded that it varied on each employer's engagement. Senator Johnson asked, by employers transitioning to HSA, are employees becoming more engaged with their healthcare decisions. Mr. Kreiling responded in the affirmative, and Regence is working on providing tools to make it easier for consumers to research their decisions.

Senator Lakey asked what number is being invested into the employee's HSA. Mr. Kreiling explained that it varies among employers. He clarified that some employers will match the full-allowed amount, but other employers will not contribute any amount and that tends to disincentivize employees from becoming more engaged. Senator Lakey followed up by asking for examples of the goals that are set and the incentives that are offered to hospitals. Mr. Kreiling explained that they try to align their goals with goals from CMS (Center for Medicare and Medicaid Services); by 2019, 51% of their reimbursement will be tied to achieving certain quality metrics (i.e., hospital safety rating, readmissions, etc.).

Senator Lakey inquired about what is considered a high-performing network. Mr. Kreiling responded that the definition varies depending on what the employer is seeking. He explained that some employers may narrow the network to a specific clinic for employees that have specific physical demands (i.e., firefighters, police force, etc.). This clinic may have a higher level of understanding for the special needs of the employees, and Regence would create a design based on the employer's needs for a high-performing narrow network. Senator Lakey asked how Regence is making members more aware of these engagement tools. Mr. Kreiling explained that at times they will set up kiosks in the employer's buildings that demonstrate engagement tools available to employees, email or send home mailings to employees, and some employers will offer gifts cards for their employees to reward engagement.

Senator Lakey asked what analytics or insights have been reviewed and how they have changed or improved. Mr. Kreiling responded that by analyzing their data for emergency visits, for example, they have been able to work with a physician group to make the proper staffing adjustments needed in a clinic to reduce ER admissions and costs. Representative Anderst asked if they offer biometrics at the time of enrollment. Mr. Kreiling responded that it varies by employer; Cambia Health Solutions, as an employer, offers biometrics and has put an incentive in place for their employees to do biometrics.

Simplot Plans - Ms. Aleasha Eberly

Co-chair Lakey called upon Ms. Aleasha Eberly to begin her presentation. Ms. Eberly introduced herself and began her presentation by providing some background regarding the Simplot company. J.R. Simplot is an Idaho-based company, but they do operate in 37 states, as well as internationally. The plan that she addressed is for the US employees, and there are 14,000 lives covered in this plan.

Highlights and additional facts for Ms. Eberly's presentation included:

- Simplot changed their plan because they could no longer afford to continue with their grandfathered status. The company has always desired to maintain a 70/30 cost balance; yet achieving that balance within the existing plan design would cause significant cost increase to employees.
- The process to change their plan started with a meeting of their executive team. The executive team provided 5 guiding principles to inform the process:
    - Ensure that employees and their families had access to health insurance;
    - Partner with employees and family members to support and achieve healthy lifestyles;
    - Ensure that any health plan changes support the total rewards value proposition to attract and retain talent;
    - Ensure compliance with the ACA (Affordable Care Act) and overall sustainability with the Simplot health plan; and
    - Manage the benefit trend and design to contain costs to the businesses.
- A project team was created that included a cross-section of HR representatives from across the 4 businesses in the company, to help them come up with the recommendations that would go forward to their executive team.
- Simplot hired an external consultant to utilize their expertise, data analysis, and the unique approach they have to evaluate these opportunities.
- The project team developed 4 objectives:
    - Cost-sharing - encourage the right behavior within member population (i.e., encourage spouses to get on their own health plan through their own employers, discount for non-tobacco users, HSA funding, etc.);
    - Protection - ensure employees are still protected from catastrophic medical situations;
    - Education and tools - provide resources for employees so that they can make better decisions; and
    - Accountability - ensure employees are using the plan wisely.
- Simplot decided to provide a high deductible health plan (HDHP). Some reasons behind this decision included: HDHPs are becoming more common among private employers, it was a more affordable entry point, and HDHP designs make more transparent the cost of medical services and pharmaceuticals.
- The company did a full replacement of their health plans because there is often resistance to change and they found that HDHPs are becoming an industry trend.
- The health coverage includes: medical/prescription, dental, vision, and a telemedicine program.
- Simplot's HSA provider supports contributions from both the employees and Simplot.
- The decision making tools available to their employees are: Best Doctors, CostAdvisor, and Wiser Health.
- The wellness program includes: health assessments, health screenings, tobacco cessation, health coaching, etc.
- Simplot still utilizes a PPO network, but they have increased the disparity between the two to encourage in-network utilization.
- Deductible is set at $1,500 for an individual and $3,000 for families; a little above what the IRS requires, but enough so that they have not been impacted by indexing to date.
- Coinsurance is 20% after the deductible has been met, no cost for preventive care, and out-of-pocket maximum of $4,000 for an individual and $8,000 for families.
- Union negotiations were tough and a lot of education was involved for the conversations that were started early on in the process. A variety of communication tools were used to talk to employees; communication was done frequently and in small increments.

- An analysis where 2013 claims data was applied to the 2015 plan design to see what the impacts would be concluded that 70% of the population would be better off if they had the exact same claims. 25% of the population would experience a financial impact in excess of $1,000. Some of the reasons for this financial impact was due to: having a spouse on the plan, tobacco use, and heavy utilization (those who spent a lot of money throughout the year, but didn't necessarily hit the out-of-pocket maximum).
- Health plan impacts included:
    - Most people saw no change or a slight reduction in their health plan contributions;
    - 80% of those who choose to enroll in the tobacco cessation program quit;
    - 76% adherence to preventive screenings on time;
    - 36% of people chose to do health screenings and health assessments;
    - Decision making tools were implemented; and
    - $7.5 million in employee and employer contributions to HSA accounts.
- Regarding the plan cost, in year 1 there was an increase of less than 2% and less than 4% increase in year 2. Medical services decreased in year 1 by about 10% and there has been a 2% increase from the first year's number.
- Top 7 lessons:
    - Communication;
    - Strong vendor partnership and new tools;
    - Generous HSA contributions are important to transition;
    - Expect significant reactions regarding pharmacy costs;
    - Aggregate family deductible is difficult;
    - Plan for the transition of your FSA to an HSA; and
    - Recognize that it is complex and will take time.

Discussion:

Senator Nonini asked for the number of Simplot employees. Ms. Eberly replied that Simplot has 7,500 employees in the United States and 10,000 worldwide. Senator Nonini followed up by asking if the tobacco cessation statistic is less than two years old. Ms. Eberly explained that the tobacco cessation program had been in place before the new plan design, but the statistic rate did go up due to encouragement from the new health plan. Senator Nonini asked if the TPA determined which HSA provider Simplot should use. She answered that Simplot had performed a request for proposals in an effort to make their own decision; they did ultimately choose the vendor that happened to be partnered with their TPA.

Senator Patrick asked Ms. Eberly to elaborate on the increased out-of-pocket costs for the employee's pharmacy. Ms. Eberly explained that for pharmacy drugs that have been determined by the U.S. Taskforce on Preventive Services to be preventive in nature (i.e., diabetes drugs, cholesterol lowering drugs, etc.) have a $10 co-pay, regardless if the deductible has been met or not. Representative Anderst asked if any of the companies consider concierge care in areas where it may be an option. She replied that there was some discussion regarding this, but it would be difficult to be utilized within the confines of a HDHP. He followed up by asking if Simplot would have pursued a different course if their employees had been solely located in Idaho. Ms. Eberly answered that one of the reasons for having pursued this course of action was due to the fact that so many of the employees work in other states and countries. While she cannot be sure if they would have made the same choices if all of the employees had been in one state, they definitely would have had other options that could have been considered.

Co-chair Wood asked if Best Doctors is a national program. Ms. Eberly responded that it is available across the United States and internationally in some cases. He followed up, asking if Simplot explored the option of providing an additional incentive of HSA contributions for those who do not

smoke, and also an incentive for those who are not obese. She explained that regarding tobacco cessation, the individual is receiving savings on the contribution side versus someone who is using tobacco. While they did discuss the obesity issue, they felt it would be better addressed by their wellness program. She added that Simplot tries to be thoughtful on how they can provide incentives for a behavior that applies to their entire population.

Senator Schmidt asked what the cost-balance had been between the employer contributions and the employee contributions before the new plan change. She stated that Simplot was closer to 80/20 with the employer paying 80% of the plan costs. At this time, it is about a 70/30 cost-balance. Representative Anderson asked what the percentage paid by the employee versus the employer is in the current plan. She explained that in-network, once deductible has been met, the coinsurance is 20% and the plan pays 80%. If employees choose to go out-of-network, then the coinsurance is 40% and the plan pays 60%. He followed up by asking, of the total compensation that is being provided, how big of a component is the health plan of the total compensation package. She responded that this will vary given the wide range of pay for the variety of positions their company holds. She explained that what Simplot tried to do was to minimize the per-paycheck contribution to try to ease the burden on their lower paid employees.

Representative Anderson asked if Simplot had looked at any other options besides HSAs. Ms. Eberly responded that they did explore alternatives to the HSA, but they liked HSAs because it is portable and it provides the triple tax advantage. Representative Anderson followed up by asking if the project team consisted of solely HR representatives. She answered that the team was primarily made up of human resource professionals, but those HR professionals had an accountability to meet with their business leaders and return with feedback. The team also conducted several focus groups from employees across the county. Representative Kloc asked what has happened with the team that was put together - has it grown or decreased. Ms. Eberly explained that the team that had worked on preparing the plan design recommendations had been made up of HR representatives, HR managers primarily, from their businesses. The benefits team that manages the structure has stayed the exact same size from 2014 to now; it is a team of 3 people that focus on the health side.

Select Health Plans - Mr. Jerry Edgington

Co-chair Lakey called upon Mr. Jerry Edgington, Vice President and General Manager in Idaho for Select Health, to begin his presentation. Mr. Jerry Edgington began his presentation by introducing himself and expressing gratitude towards the committee for allowing the carriers to present and be part of a solution.

Highlights and additional facts for Mr. Edgington's presentation included:

- Select Health was established in 1983 and it is a not-for-profit health plan. They serve 100,000 members in Idaho alone, and have a strategic alliance with St. Luke's Health System.
- Select Health began a program in Idaho that provides a small grant to 25 grass-root organizations to do work in the community.
- Fee-for-service is not a good formula to operate under if one wants to address the cost of healthcare, become integrated, and improve the quality of healthcare.
- Industry experts suggest that 30% to 50% of healthcare spent is redundant care, wasted care, or even harmful care.
- Providers should be given a stable budget, and incentives should be provided for managing within that budget. The rest of the cost-savings should go to the consumer, and carriers should only get what they need in order to operate.
- The bottom 50% of the population accounts for 3% of health spending. The top 20% of the population account for 80% of health spending. The top 5% of the population account for 50% of health spending.
- Carriers and clinicians are focused on eliminating waste since it will have the biggest impact on health spending.

- Physicians/providers, carriers, plan members, and employers are accountable for managing healthcare costs.
- Employers play a role through plan design by incorporating a tier plan design for pharmaceuticals.
- Align financial incentives through the pay-for-value mechanics to manage costs by:
    - Accountable parties agreeing on best practices;
    - Sharing data; and
    - Care coordination and disease management.
- A large mass is needed to assume total risk for a population, especially if it is an unstable population. Select Health's group plans retention rate is 90%.
- Ideas for the State of Idaho to manage their plans:
    - Many large employers use a private marketplace to offer different options for plan benefits, or offer multiple plans within a certain carrier;
    - Offer employees personal choice (e.g., plan benefits, out-of-pocket costs, and provider networks);
    - Facilitate competition; and
    - Provide administrative efficiencies.
- Pay-for-value works in fully-insured arrangements; if you have self-funded benefits, you continue to pay for fee-for-service.

Discussion:

Senator Johnson asked what the 'civilian non-institutionalized' refers to on slide. Mr. Edgington stated that he believed this term refers to those who are not federal employees, and non-federal plans (i.e., Medicaid, Medicare, etc.).

Senator Schmidt asked who is the most accountable for managing healthcare costs. Mr. Edgington opined that the provider has the most influence due to the complexity of the system, the complexity of care delivery, and their understanding of what a treatment program should be. He added that the next person with the most influence is the plan member and that is through ensuring they are following their treatment orders by the physician. Co-chair Lakey asked if Mr. Edgington could expound on his comments about physicians 'doing the right thing' and on the potential financial penalties. Mr. Edgington explained that if they can provide the care needed within constrained resources, then it is best practice.

Pacific Source Plans - Mr. Josh Bishop

Co-chair Lakey called upon Mr. Josh Bishop, Vice President of the Idaho Region for Pacific Source, to present next. Mr. Bishop began his presentation by introducing himself and stated his background as a pharmacist by training as well.

Highlights and additional facts for Mr. Bishop's presentation included:

- Mission, vision, and values are listed on slide 3.
- Pacific Source operates across Oregon, Idaho, and Montana. They are a taxable, not-for-profit mutual benefit corporation that employs 800 people, and has 275,000 members.
- Market dynamics:
    - ACA driving increased taxes and fees;
    - Individual market is causing significant financial pressure;
    - Carrier and provider consolidation;
    - Carriers are exiting some markets;
    - New technologies and treatments; and
    - Shift from volume to value.
- Their goals are to reduce healthcare costs, improve the health of the population, and improve member and patient experience. Another goal they have is not to maintain their current role in healthcare, but

to shift more responsibilities that health insurers have taken on traditionally to the providers, and help providers be more effective at the care they deliver. This ties into a fourth goal, which is to empower and support their provider partners.

- The integrated partnership model includes: purchasers, consumers, the health plan, and providers. Pacific Source believes in engaging all stakeholders in a facilitated, partnership governance model, one where everyone is coming together. They've been able to transform the healthcare system, and improve both quality outcomes and cost outcomes in small markets with this model.
- It is important to communicate with members in technology platforms that are easy for them to use. Data must be converted into actionable information for both patients and providers.
- Leveraging clinically integrated networks with provider partners.
- Pacific Source believes if an employer takes an approach that can facilitate a community model that empowers individuals and healthcare decision makers, there will be better outcomes for employees and other Idahoans in those communities without sacrificing choice, and at the same time improving quality and lowering cost.
- Medically administered drugs and prescriptions drugs make up 15-25% of total healthcare spending - in some unfortunate events it may be 30%. It is a matter of time before this medical and drug proportion of the healthcare spending eclipses the in-patient medical and surgical spending.
- As the costs of prescription drugs rise, the utilization rises, and as the population age rises, the costs are going to continue to rise. With the nontraditional marketplace, the consumer himself is not paying for the drug itself, and that is a problem.
- Pacific Source recommends combining medical and pharmacy systems. By combining both systems, one can manage the whole spectrum of care and ensure that the drugs are being administered in the right setting and that they are using the right medications.
- It is important to consider vendor selection, and the roles and responsibilities the vendors have. They have found it very important to create a separation between the pharmacy benefit company and the plan; interests are not always aligned.
- There is a trend of empowering medical homes to take care of populations, and for pharmacists to be part of the medical home. Pacific Source has created a revenue model to allows pharmacists that are employed by clinics to take care of the most complex patients with complicated drug regimens.
- Patient engagement is vital, especially in mobile platforms. If patients are not going to the doctors or accepting phone calls from case managers, they will not get better. The spending for this portion of the population will continue to increase if they are not engaged.
- The best model is where the employer, as well as the carrier, are willing to implement a benefit structure that drastically disincentivizes patients to not engage. For example, when high-cost patients are identified to receive high intensity case management services and they do so, increase the 80/20 out-of-pocket costs to 90/10. If the opposite is done, decrease the 80/20 benefit to 70/30, with the employee paying the 30%.
- Pacific Source believes that with a robust partnership model, with technology driven cost-control medical solutions, and with a wellness platform, you should be able to achieve: much better outcomes, lower costs, higher productivity from employees, and ultimately a sustainable healthcare system.

Senator Schmidt asked if Pacific Source has experimented in different payment methodologies. Mr. Bishop responded in the affirmative; and in some cases this means leveraging the community health excellence fund, for example, to provide innovative grants to providers who want to transform their care. In more advanced cases, they may create a contract mechanism that spans over years, that will allow provider partners to take the appropriate risk they are willing to take, that is benchmarked to performance metrics, and ensure that together they are monitoring those metrics and providing both upside and downside risks for the population defined.

Senator Schmidt followed up by asking if there is a preponderance of payment methodology that Pacific Source uses. Mr. Bishop responded that there might not be a preponderance, but there is a shift; they are moving from grant mechanisms to sustained clinics and are allowing them to transform to more risk models.

Co-chair Wood asked if Mr. Bishop would expand on their CCO (coordinated care organization) model in Oregon, and how closely it resembles an ACO (accountable care organization). Mr. Bishop explained that Pacific Source has acted as a carrier intermediary; they contract with the state of Oregon in this model, receive funds, and have seated governance to a community board of consumer stakeholders. In this model, Pacific Source has kept the GNA and margin under a ceiling that the community is comfortable with, provide full transparency to their books and clinical outcomes, and the governance board decides how they are going to manage the population. Co-chair Wood inquired if in this model the carrier was acting as the disinterested, third party, holding the money until the appropriate conditions of the contract are met between the state of Oregon and the Medicaid population, and in this effect they act as an ACO. Mr. Bishop elaborated that in the contractual mechanism, the carrier (Pacific Source) for those two communities, takes downside risk. He noted there is no downside risk that is shared with the community or the Oregon health authority. They take the downside risk, cap their margin and GNA, and any surplus is returned to the community.

Co-chair Lakey asked if this model is provided to public or private employees. Mr. Bishop responded that at this time, it is provided for the Medicaid population. It has been envisioned that this model be extrapolated to public employees and other large, insured populations. Representative Anderson asked why they choose to organize under the statute of a taxable, not-for-profit organization. Mr. Norm Varin, Mr. Bishop's colleague, answered that they are not owned by any specific entity, they are there to provide a benefit to the community they serve. He added that any margins Pacific Source collects are taken into a reserve to take care of any capital investments they need to make or any claims they may need to pay in the future. Co-chair Lakey asked Mr. Bishop to expound on how they have made their wellness program effective. Mr. Bishop explained that the best measure of success is the adoption and engagement of patients. When they have seen a wellness program packaged with a directed network and an engaged set of consumers and healthcare providers, they have also seen lower trends and premium prices decrease.

Senator Schmidt asked if they see any potential changes to the individual market that is causing significant financial pressure. Mr. Bishop responded that at some point it will need to stabilize, but at this time they are seeing premiums increase across the markets and major carriers are also choosing to exit the market, which is decreasing choice for the consumers. He emphasized that at some point there will need to be stabilization, both in the insured lives increasing and generating a stable pool of lives, and premiums stabilizing in a way that they can cover the claims.

Accountable Care Organizations - Mr. Dave Self

Co-chair Lakey called upon Mr. Dave Self, Chief Administrative Officer for St. Luke's to present next. Mr. Self introduced himself and provided some professional background. He began his presentation by explaining that the concept of accountable care organizations (ACO) has been stretched.

Highlights and additional facts for Mr. Self's presentation included:

- An ACO at its core - CMS intended it to be an accountability between the people receiving the care, the people providing the care, and the people paying for the care, and sharing the risk among those parties. The true intent is to align the incentives between all the parties.
- An ACO was intended to be comprehensive in the services it provided, but did not necessarily have to include all the providers in the community.
- A key tenet for ACOs is that there should be a fixed amount available to the provider of care, and that they should function below that. There are types of ACOs that are fee-for-service, but they still have a shared risk component, and typically there is a withholding to the provider which the provider earns back by hitting certain quality measures.
- Ensuring quality outcomes is key and central to the concept of the ACO. Most carriers that work with ACOs are working with them to define those quality outcomes.
- The number of ACOs in both public and private programs has grown to 838 since 2011. Approximately 28 million Americans are covered under an ACO arrangement, 8.3 million of those are in Medicare ACO

programs, 2.9 million are in Medicaid ACO programs, and the remaining are in some form of commercial or private sector ACO.

- Transparency is another important aspect of ACOs; they must gather data, turn it into actionable information, and share it with the providers of care so they can improve outcomes and reduce costs over time.
- ACOs are not pilot programs. Most ACOs require a 5-year commitment; the minimum under Medicaid ACOs is 3 years. The reason for this is because behaviors and practice programs do not change quickly.
- ACOs include a strong, risk-sharing component; this can be upside or downside risk.
- ACOs can also be used in the creation of a private employer marketplace where they have agreements with several provider networks or carriers, and they offer them to their employees as a choice. The reasons for this include:
    - Allows employers to define their contribution amount;
    - Allows the employer to potentially enhance employee satisfaction given multiple choices;
    - Allows a budget to be created wherein employees know what their maximum liability will be; and
    - Allows for incentives for participation in disease management programs.
- The ACO concepts are separate from funding: 1) how a plan is funded is up to the employer 2) an ACO is a relationship with a provider community. Both concepts together can craft a creative solution that allows surety on what will be spent by the employer, surety on the expectations of the employee about their responsibilities. The provider can be put in the position of knowing what they will be paid with some surety, which will allow them to focus on their work with the population that needs them the most.

Co-chair Lakey asked how a structure can be changed from fee-for-service to a structure similar to an ACO. Mr. Self responded that it depends on the arrangement with the providers. He explained that it largely depends on whether it is a capitated per-member-per month arrangement or a fee-for-service arrangement in the ACO because there can be risk-sharing among those different funding mechanisms. If it is fee-for-service, there can still be temptation for providers, but employers are looking for surety and offering incentives for providers that will operate efficiently. Aligning incentives starts with the benefit construction of the program, and allowing the employee to know, before they become a patient, what their out-of-pocket costs are going to be.

Co-chair Lakey asked how the quality measures may be different from the CMS list in an ACO. Mr. Self explained that the CMS list is catered to the Medicare population that would not necessarily align to pediatrics, for example. It is about ensuring that there is network adequacy in place and the ability to serve the population at the point of service. Co-chair Lakey asked if he could provide any specific examples of quality measures. Mr. Self responded that examples include diabetic control (A1C levels) and BMI (body mass index). Ideally, an ACO should be consuming both claims data from the third-party administrator as well as clinical data. The goal for ACOs should be to identify the rising risk.

Senator Schmidt asked how ACOs would function in rural or frontier areas. Mr. Self responded that not every area can be served well by an ACO, such as rural areas. A blended model would be needed so as to not penalize individuals who could not be part of the ACO model .

Co-chair Wood asked if ACOs are fairly scalable. Mr. Self responded in the next generation of ACOs, under the CMS definition, they must have at least 10,000 enrollees to participate. If an ACO is deemed rural in terms of their service area, it can go down to 7,500 enrollees. Setting the CMS definition aside, there is not a standard definition for ACOs. Co-chair Wood followed up by asking what platform he would recommend the state consider to afford the state the most flexibility going forward to offer either one or a combination of plans to employees (i.e., regularly insured, self-funding, etc.). Mr. Self responded that the state is in a unique position because it has one of the most durable funding mechanisms he has seen. He opined that there does not seem to be a significant downside to transitioning to a self-funding mechanism. The majority of state employees are in the more metropolitan areas of the state which should allow for the state to consider closer

relationships with defined networks of providers in order to create ACOs. There should be careful consideration given to accommodating the employees in the more rural areas, as well. Co-chair Wood stated, with respect to ACOs, it seems that they would be the best model available to make sure that the capability of all providers, including mid-level providers, are used in their best role. Mr. Self agreed with Co-chair Wood's statement.

Senator Thayn's Presentation

Co-chair Lakey invited Senator Thayn to present next. Senator Thayn began his presentation by introducing himself and describing the serious issue of medical costs.

- Medical costs are 18% of the GDP in the United States versus the 9% industrialized nation average.
- $220 million of state funds were allocated to state employees health insurance.
- 89% of all medical spending is controlled by insurance companies and federal Medicaid and Medicare programs.
- Medical costs are high due to lack of focus on primary care, medical spending being controlled by insurance companies, and because insurance is used to pay for primary care, but 40% of funds are wasted in paperwork costs.
- The state component to address the issue of healthcare costs could include funded HSAs for employees, right to shop, and changing the manner in which primary care is paid. This will help private citizens transition to funded HSAs and utilize cash for primary care expenses instead of billing the insurance company.
- 2016 Senate Bill 1346 attempted to direct the Dept. of Administration to provide funded HSAs as an option for state employees, but it did not pass.

Representative Anderson asked if within the system he described it would be a problem for individuals who lack the expertise or knowledge to negotiate for discounts in the manner that insurance companies do. Senator Thayn replied that he did not believe it would. He clarified that he is not suggesting that entities's insurance companies not negotiate price anymore. However, for employees who have the HSA funded plan, they may negotiate for discounts on non-emergency issues for example. Senator Patrick inquired about speciality centers that hospital centers use as profit centers. Senator Thayn opined that hospitals have poor business models; they are focused on extracting more money from the citizens of Idaho, rather than providing the services. He suggested that competition may be needed for hospitals to discover where they have waste.

Referring to the Indiana model and their use of HSAs, Co-chair Lakey asked if Indiana also used an all-in-approach similar to Simplot. Senator Thayn explained that they started with an optional approach, and they had a transition period to help employees build enough funds to cover their deductibles.

Blue Cross of Idaho Plans - Mr. Dave Jeppesen

Co-chair Lakey called upon Mr. Dave Jeppesen, Chief Marketing Officer for Blue Cross of Idaho (BCI), to present next. Mr. Jeppesen began his presentation by introducing himself and providing historical context about Blue Cross of Idaho.

- Blue Cross of Idaho is a mission-driven organization dedicated to being the best choice for healthcare coverage.
- Blue Cross of Idaho is a mutual not-for-profit Idaho company. They are Idaho's oldest and largest healthcare insurer.
- They operate in all the markets, including: qualified health plans (exchange), grandfathered plans, and grandmothered plans. They also operate in the group market space, as well as in government programs.
- Healthcare is facing an affordability coverage crisis. A shift from fee-for-service to value-based care should be made to address this issue. BCI pays for performance with physicians, and the way a physician can be paid more would be to operate efficiently. This provides an incentive for physicians to operate efficiently and helps decrease healthcare costs.

- BCI works with each group individually to develop a way for them to achieve their goals and transition from a fee-for-service to a value-based care system in a manner that makes sense for the employer.
- BCI employs some physicians and pharmacists in order to stay current on the most recent medical practices. They also utilize nurses and social workers to do case coordination to solve a gap that exists in the system today, primarily in the open network. It's difficult for physicians to know what has happened across the continuum of care of the patient.
- Pharmacy is a big driver of increasing medical costs. Multiple strategies (i.e., specialty guideline management, site of care, generic programs, etc.) are critical to address this issue.
- Healthcare innovation is booming. Venture capitalists are investing in finding ways to fix the broken healthcare system. BCI is paying close attention to any methods that might work for their organization and the citizens of Idaho.

Discussion:

Senator Schmidt referred to the fee schedule for physicians, and asked if there was a conversion factor from one speciality to another. Mr. Jeppesen elaborated that they pay in accordance to conversion factors for each speciality. Representative Anderst inquired about utilization as it relates to HSAs, and asked if there are studies that state that people are less likely to seek care if they have HSAs. Mr. Jeppesen responded that preventive care and preventive pharmacy is included free of the deductible. They do see a reduction of utilization for those who have HSAs, but he does not know if that can be attributed to HSAs.

Senator Johnson asked, in regard to the pay structure for the high-efficiency/low-efficiency performing physicians, if this type of system will impact the rural parts of the state where there is a struggle to provide care. Mr. Jeppesen responded that BCI has been monitoring the pay structure to make sure they are not unduly rewarding for a rural setting. They have not to date detected that they are negatively impacting rural areas.

Co-chair Lakey inquired about the difference between the grandfathered plans and grandmothered plans. Mr. Jeppesen elaborated that these terms only apply to the individual market. He explained that plans that were issued between 2010 to 2014 in the individual market space that can only continue through 2017 are called grandmothered plans. Grandfathered plans are those in existence on or prior to March of 2010 that can continue indefinitely.

Co-chair Lakey asked if they could incorporate an HSA or an ACO in the existing state employee group insurance plan structure. Mr. Jeppesen answered that it may be possible, but an in-depth conversation will need to be done with the benefit consultant, the legal team, and the carrier. Co-chair Lakey asked Mr. Jeppesen for his thoughts regarding whether the state should continue with its grandfathered status. Mr. Jeppesen offered that keeping the grandfathered status allows the state to keep its current benefit design and continue to be exempt from the ACA requirements. However, he said, there is limitation regarding how much cost-sharing can be shifted to employees under the grandfathered status.

Committee Discussion

Senator Schmidt stated that according to many entities who have gone through a process of transition, there is an important need to communicate any proposed plan changes in advance, as well as the need to develop affirmation. Co-chair Lakey commented that at this point the committee has many options, but he was not sure they were quite ready to propose legislation. He added that they may be able to recommend small changes though. Co-chair Wood explained that at the next meeting he would like to discuss what they should do in regard to the grandfathered status, self-funding, and discuss what recommendations the committee should explore including if they should bring in a third-party consultant as Simplot did. He emphasized that the goal is to build a sustainable remodel without reducing benefits for state employees.

Co-chair Wood suggested the committee hold another meeting in October in order to address potential recommendations for the Legislature. After much discussion, the committee decided to hold their next meeting on October 25 at 10 a.m.

The committee adjourned at 4:03 p.m.