MINUTES
Approved by the Committee
State Employee Group Insurance & Benefits Committee
Thursday, September 21, 2017
9:00 A.M.
Room EW42
Boise, Idaho

Co-chair Fred Wood called the meeting to order at 9:02 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 and Jim Patrick; and Representatives Neil Anderson, Robert Anderst and Dustin Manwaring. Senators Robert Nonini and Mark Nye participated via conference-phone. Absent and excused: Representative Hy Kloc. Legislative Services Office (LSO) staff present were: Robyn Lockett and Ana Lara.

Other attendees: Sean White, Eric Sock, and Shelli Stayner, Mercer; Representative Lance Clow, Idaho State Legislature; Jennifer Pike, Office of Group Insurance; Bret Rumbeck and Kelley Carew, Blue Cross of Idaho; Nathan Pierce, St. Lukes Health Partners of Idaho; Pat Sullivan, Sullivan and Reberger; and Fred Birnbaum, Idaho Freedom Foundation. Carly Debo from Mercer participated via conference-phone.

Co-chair Wood explained that the meeting would provide the information necessary so that the committee could discuss all the necessary points and make a decision at the following meeting about which recommendations to take to the Legislature.

Co-chair Wood called for the approval of the July 31, 2017 minutes. **Co-Chair Lakey made a motion to approve the July 31, 2017 minutes. Representative Manwaring seconded the motion. The motion passed unanimously.**

Mercer Presentation: Benefit Strategy Development - Sean White, Shelli Stayner, Eric Sock and Carly Debo, Mercer

Co-chair Wood called upon Mercer to reintroduce Mr. Sock and Ms. Debo to the committee and to begin their presentation. Ms. Stayner introduced Mr. Sock as a senior consulting actuary and Ms. Debo from client management, and reminded the committee that they both were present at the first meeting and had participated via conference-phone for all subsequent meetings.

Mr. White referred the committee to the agenda on page 2 of their presentation packet.

Draft Strategic Roadmap

Mr. White stated that this was the third meeting and they were at step 4, evaluating approaches, and the goal for the meeting was to discuss options and financial impact of changes, gather feedback, and incorporate any adjustments into the final version of the strategic plan. He proceeded to slide 5, which delineated the committee's feedback in the areas of business priorities, cost priorities and employee priorities. Mr. White explained that there were four 'levers for change' in an employer strategy. Care delivery, workforce health, program design and delivery infrastructure are the four areas that can be used by an employer to implement specific strategies and solutions to impact the cost and value of the benefit to employees.

Co-chair Wood asked if there was any statutory language in Idaho Code that would prevent the State from contracting and optimizing carrier networks, direct contracting with accountable care organizations (ACOs), etc. Mr. White and Ms. Stayner responded they were not aware of any.

Mr. White proceeded to the strategic roadmap on slide 8 and explained that it assumed that any changes would not take place until the plan year July 2019 to allow time for recommendations to

the Legislature and the time needed to explore potential solutions for implementation of the new plan. He also explained that during the year 2018, they should:

- Understand value-based care (VBC) solutions available through Blue Cross of Idaho;
- Conduct exploration of telemedicine solutions in the market; and
- Assess outcomes of current Blue Cross of Idaho care management programs.

Co-chair Wood asked at what point in time should the State discuss what should be done with the third-party administrator (TPA) going forward. Mr. White explained that, as noted in the delivery infrastructure category, during the year 2018, they should conduct a request for proposal (RFP) process for medical administration, including self-funded proposals and assessment of VBC capabilities. He added that, in 2018, the work would consist of research, marketing and analysis to determine what the approach for plan year 2019 should be regarding vendor partnerships, plan design, and what the State should do in terms of value-based care.

Senator Patrick, referring to managed care programs, inquired about the incentive for people to manage their diet and take their medications regularly. Mr. White explained that there are several areas in the strategic roadmap that could assist in this area; this was also part of the idea behind the movement toward value-based care. In a value-based care system, the goal is to create relationships between primary care providers and patients focused on prevention, with the hope of improving health behaviors more effectively than perhaps employers have been able to do historically through wellness programs.

Senator Patrick inquired about reasonable compensation for telehealth doctors as compared to rates for doctors seen in person. Mr. White explained that the strategy for telemedicine was based on partnering with third-party providers (e.g., teledoc and MD Live), which is meant to provide more effective, efficient access to service in circumstances where a visit to urgent care or the ER is not necessary (e.g., ear infection); they are not meant to replace the relationships of primary care providers and their respective patients.

Representative Anderson asked about the process for understanding what VBC solutions are available through Blue Cross of Idaho - would it be done through the Office of Group Insurance (OGI) or Mercer. Mr. White responded that Mercer could help the State in this area. In general, he said, an employer would partner with a provider or consultant to conduct an RFP process for medical administration and explore point-solution programs for telemedicine options, weight/diabetes management, etc.

Appendix

- Care Delivery:

At the request of the committee, Mercer proceeded to the appendix (slide 57) to discuss the savings potential for each feature. Mr. White discussed the VBC strategy to include ACOs, patient centered medical homes, direct primary care options, etc. Mr. Sock pointed out that across all the considerations, the savings impact is due both to the structure of the program and significantly due to the utilization of the program. He explained that to maximize the savings, they had to maximize the utilization of the program; the struggle would be encouraging individuals to utilize the models.

Co-chair Lakey inquired about the telemedicine target utilization of 10%-15%. Mr. White responded that it was an industry benchmark. He explained that telemedicine was meant to target nonemergency use, inappropriate use of urgent care or primary care, or utilization that could be treated effectively through a telemedine solution.

Mr. White proceeded to the topic of care management and explained that, with the State's current fully-insured arrangement, the carrier provided those services. However, if the State chooses to transition to a self-funded model, it can still access those services through the medical carrier or it can choose to carve certain services out. Part of the strategy is to understand whether there

are better solutions available through third-party solutions to replace those services, and ultimately implement whatever is determined to be the best, in-class program for the State, the employees, and families covered under the program.

Mr. White spoke to expert medical option (EMO) programs used to improve diagnosis and treatment decisions and outcomes for those with complex diagnosis and high-cost claims. He stated that in roughly 10%-15% of cases, these programs change the diagnosis of patients; this exposes the fact that every provider, in any community, is not equal from a quality-level and studies show that there is a great deal of misdiagnosis and waste in the system. This is a solution that an employer can adopt to not only provide a great resource for employees and their dependents, but to provide better quality care and manage costs more effectively. In regards to on-site/near-site clinics, Mr. White said that they provide assistance with urgent care issues or occupational health concerns; they are not designed to replace primary care physician (PCP) relationships.

Co-chair Lakey inquired whether direct primary care could be combined with EMOs. Mr. White responded that it potentially could overlap.

Mr. White moved on to the next solution - centers of excellence (COEs). In certain surgical interventions, the employer would provide a benefit to an employee to use a COE; the arrangements typically include a bundled payment solution for the entire surgery. It's a strategy for employers, especially those with employees in rural areas, to provide an option for better quality outcomes for their employee populations.

Ms. Stayner addressed the potential to integrate the state employee population into Medicaid, with a Medicaid fee schedule or reimbursement. Co-chair Wood inquired as to how many states have implemented this. Ms. Stayner responded she was not sure, but would provide the information at a later point. Mr. White added that this was a relatively new strategy that government groups working with state medicaid programs look into as a potential option; it is not common in the market today.

In regards to their previous discussion regarding care management programs, Co-chair Lakey emphasized a need for an evidence-based component to evaluate results.

- Workforce Health:

Regarding well-being, Mr. White said that any program implemented should be focused on evidence-based best practices with outcomes-based incentives. The strategy recommended by Mercer was to explore best-in-class point solutions to address weight management/diabetes prevention, cancer, maternity, and musculoskeletal issues. As addressed in previous meetings, the strategic roadmap includes a tobacco surcharge, typically an additional $50-$100 per month (via affidavit).

- Program Design:

One program design consideration is to implement a transparency solution to allow employees and their families to shop for high quality, low-cost care within the market.

Senator Patrick suggested that shopping the market for a less expensive procedure (e.g., MRI) would need to be tied to a high-deductible health plan (HDHP) or health savings plan (HSA) and opined that it might not be successful otherwise. Mr. Sock commented that employers who offer high-deductible health plans have a certain expectation that their employees will use their healthcare wisely; those health plans cannot be as effective unless they have transparency tools to understand pricing. Representative Anderst inquired how to incentivize employees to use transparency tools. Mr. White responded that some employers have included incentives (e.g., referenced-based pricing) for use of transparency tools.

Advocacy solutions are a resource for employees and their families to better navigate the healthcare system. This could include explanations of benefits and assisting patients in finding providers for those diagnosed with medical conditions.

In the roadmap, Mercer included exploration of salary-based strategies, whether that be salary-based contributions in terms of monthly payroll deductions, or account contributions to HSAs, health reimbursement accounts (HRAs) or flexible spending accounts (FSAs) based on employee salary.

A spousal surcharge is an additional surcharge that an employer will transfer to an employee who chooses to cover a spouse when that spouse has access to coverage from his/her own employer; typically $50-$100 per month. Representative Anderst asked if there were studies that show that a married couple performs better on the same health plan. Mr. White responded that he had not seen studies to that effect; on average, a spouse costs 10% more than the employee.

Additionally, as a reminder, the State has options available to address the retiree population, although the focus is on the active employee health benefit program. Also, the State can look at aspects within the Life Insurance Plan Management.

- Delivery Infrastructure:

The committee proceeded to slide 62 to discuss plan management. In regards to the medical plan, there was discussion about conducting an RFP for medical plan administration. In regards to pharmacy plan management, the State currently partners with the same provider for medical and pharmacy benefits; it's more common for larger employers to carve-out pharmacy benefits and partnering with a larger vendor or other employers to drive down costs.

Another option to consider is a catastrophic plan; this is an option to expand choice. This could be offered for certain segments of the population to address the affordability issue at a very low-cost or no-cost option. Mr. Sock explained that it addresses the affordability issue through a monthly contribution perspective. This would introduce more risk on the members' part if they experience a significant medical event and could cause the members to pay higher costs.

Mr. White reminded the committee that dental and vision plans are an important part of the State program and the committee has to understand what market options are available.

Senator Patrick asked if Mercer had any thoughts about including holistic medicine in the State's health plan. Mr. White responded that it was a decision to be made by individual employers. If the State of Idaho is fully-insured, coverage in this area would be up to the carrier; if the State transitions to a self-funded model, coverage is up to the State. He reminded the committee that its goal was to have evidenced-based practices and anything added to the plan would need to fall into that category.

The committee recessed for a break at 10:28 a.m.

The committee reconvened at 10:44 a.m.

Benchmark Review

Mr. White directed the committee to slide 10 to discuss plan design benchmarks. He explained that the recommendations were influenced by the committee's feedback requesting the program to be at the market median or slightly above it. Slide 10, he said, shows the current PPO program and its high-level features with comparisons to plans from Mercer's National Survey of Employer-Sponsored Health Plans for large government employers, large state government employers and nationally for large employers across all industries. He described the State's current deductibles as well below what is seen in the market; out-of-pocket maximums are fairly in-line or maybe slightly higher than what is seen in the market.

PPO Plan

- Deductibles: well below what is seen in the market (generous);
- Out-of-pocket maximums (OOPM): in-line or slightly higher than the market; and
- Cost-sharing: below what it seen in the market (generous).

High-Deductible Plan

- Deductibles: single employee is fairly in-line or slightly high and the family deductible is quite higher than the market;
- Out-of-pocket maximums (OOPM): high;
- Plan is less generous given there is no account funding from the employer into an HSA; and
- Cost-sharing at 30% is less generous.

Mr. White stated that Mercer understood the plan was designed to achieve a certain end, but when compared to HSA plans offered, the current high-deductible approach was less generous than the average plans in the market.

Mr. White proceeded to address employee contributions for both individual coverage and family coverage. He explained that, in both comparisons, the amount that employees are required to pay toward coverage is well below what is found in the market - both on a dollar basis and a percentage basis.

Financial Impact of Medical Plan Changes for 2019-2020

Mr. Sock explained that, in this section, they had not explicitly included the potential impact of other strategies under consideration in the appendix. He stated that, in general, the impact of the State transitioning to a self-funded plan has the impact of lowering the projected 2019 costs due to elimination of some fixed fees. However, in this section, Mercer did not take this into account; they only delineated the potential savings in the proposed plan versus the current plan. The projected 2019 costs are based on the most recent estimates provided.

The proposed plan design would eliminate the traditional plan and only include the PPO and HDHP plans.

The proposed PPO plan would:

- Increase deductibles to $500 for an individual and $1000 for family coverage;
- Increase OOPM slightly;
- Decrease co-insurance from 85% to 80%;
- Increase office-visit co-pays from $20 to $25;
- Introduce mail order co-pay structure for prescription drugs; and
- Decrease the actuarial plan value by 2.5%.

Representative Anderst noted that the proposed HDHP plan decreased the OOPM for family coverage. Mr. White explained that it was designed this way to become more in-line with median benchmarks for the market. Representative Manwaring asked if the 7.5% migration to the HDHP was a market median. Mr. Sock responded that it was an estimate based on the design put forth, as well as the contributions listed on the following slide. The current HDHP enrollment is much lower than this percentage. With this potential design change, as well as the differentiation in contributions, it would drive more employees to the HDHP. Representative Manwaring asked how much savings the State would incur by the 7.5% migration from the PPO to the HDHP. Mr. Sock responded that the savings was primarily driven from the proposed less generous PPO plan and the proposed increase in contributions for the PPO plan. Senator Johnson requested information regarding the actuarial values for the benchmarks.

Representative Anderson inquired about the breakdown in pricing and percentage on slide 12. Mr. White responded that the difference between percentages and dollar amounts on slide 12 was due to different average costs. He explained that, for example, the $171 for the family PPO plan represented 9% of the State's total cost per month, and the benchmark of $349 for 'Goverment 500' represented 24% of the average cost per month for employers within that survey segment.

Self-funding Financial Impact Analysis

Senator Patrick inquired about the potential $13 million in cost-savings to the State by transitioning to a self-funded model. Mr. Sock directed the committee to slide 20 where a side-by-side comparison for a fully-insured approach and a self-funded approach was presented.

Comparison:

- The claims would be the same under both approaches;
- Administrative fees would increase slightly under a self-funded model;
- Premium taxes are payable under a fully-insured approach, but would cease under a self-funded model;
- Caveat: since the State, under a fully-insured model, pays premium taxes to the State of Idaho, there would be an equivalent offset to revenue, but specific to the benefit plan, there would be a significant savings;
- The healthcare reform fees decrease from $41.42 to $0.28 per employee, per month, under the self-funded arrangement; this drives the majority of the savings; and
- The per employee per month fixed cost would decrease from $102.47 to $45.44 under a self-funded model.

Co-chair Lakey asked if the $13 million in savings was directly correlated to a reduction in revenue to the state or if it stemmed from the healthcare reform fees. Mr. White explained that the savings was focused purely on the benefit plan; it includes the savings from the premium tax being removed from the benefit plan. However, the revenue the State receives for all premium tax statewide for all insured plans would decrease. Co-chair Lakey asked if the true savings, when the revenue impact to the State is taken into account, was less than the $13 million in savings mentioned earlier. Mr. White responded in the affirmative.

Representative Anderson asked whether the State would lose insurance protection if it moved to a self-funded model. Mr. White responded in the negative and explained that it's a matter of changing how healthcare was financed and paid. The same level of insurance protection would remain for the individuals. He further explained that if the State converted to a self-funded model, it would take full liability for claims experienced. However, he said, since the State was a large employer, the claims were very predictable on an annual basis; while there was some additional claims exposure liability, it was not a very significant risk given the size of the covered population.

Mr. Sock referred the committee to slide 21 and described the chart as a claims distribution of expected costs based on current costs - not the risk of the population. There was a 75% probability of the claims falling within the $254.6 and $286.3 million; this was high-predictability in terms of claims expected. The chart assumed an individual stop-loss of $2 million. Mr. Sock explained that the probability of costs being below the current fully-insured premium level was 85%; the likelihood of savings was high and the claims were easily predictable.

Representative Anderst inquired about the costs to administer the claims process in a self-funded model. Mr. Sock explained that, in the analysis on page 20, a third-party administrator would still need to be paid to administer claims under a self-funded model; the cost to do so increased slightly based on benchmarks.

Senator Lakey inquired about the $2 million individual stop-loss. Mr. Sock explained that if an individual reached $2 million on an occurrence, the insurance company would pay the claim and in exchange the State would pay the premium to the stop-loss carrier for the coverage. He further explained that the $2 million was an annual number per claim for an individual member. Co-chair Lakey asked if an individual stop-loss of $2 million was a high number. Mr. Sock responded in the affirmative and stated he would not recommend a stop-loss higher than that, but would also not recommend a stop-loss as low as $150,000 for the State's group size.

Senator Nonini asked whether a change to the Affordable Care Act (ACA) fees, would affect the savings. Mr. White responded that, if something happened at a federal, regulated level to make the ACA fees cease, it would remove the financial savings from converting to a self-funding model. Representative Anderson inquired about how ACA fees are used. Mr. White explained that there are parts of the ACA that raise revenue and others that raise costs. The Congressional Budget

Office (CBO) projections for the legislation in total projected that it would be deficit-reducing over time. The ACA fees are one component, along with the excise tax, the individual mandate and the employer shared responsibility payments, that are designed to pay for the part of the legislation that costs money (i.e., subsidies on the exchange, medicaid expansion, etc.).

Mr. Sock referred to slide 16 to discuss proposed employee contributions and the objectives:

- Meet the median benchmark more closely; and
- Differentiate monthly cost to employees to drive more employees to the HDHP.

He explained that the proposed HDHP employee contribution was set at $45 which falls coincidentally close to the current PPO contribution level, and was set at this number to make it closer to the median benchmark. The proposed employee contribution for the PPO plan was set at $90, which was slightly higher than the median $83 benchmark, and should drive more enrollment to the HDHP. The other rates are based on the tiered ratios used with Mercer's clients, which are summarized in the footnotes. Co-chair Wood asked if there was differentiation between the cost for an employee with a spouse and two children as opposed to an employee with a spouse and ten children. Mr. White responded in the negative.

Mr. White explained that slide 16 was presented as a starting point; he understood that a movement of this size, in one year, around employee contribution was significant. He reminded the committee that it achieved the goal of reaching a median benchmark and that many employers phase the change over three or five years. It was a starting point for discussion and not necessarily a recommendation.

Self-Funding Overview and Strategy

Ms. Stayner directed the committee to slide 23 to address self-funding and the current State of Idaho requirements. She stated that 97% of employers with a population of 20,000 ore more are self-funded. When looking specifically at only government employers, 72% of state governments were self-funded without a stop-loss. She noted that on slide 26, an employer with a group size of 10,000 - 19,999 individuals had a median specific stop-loss deductible of $500,000. Mr. Sock added that for a lower stop-loss level, the insurance company would be responsible for higher claims and the premium would cost more (slide 27). Mr. White noted that only 25% of employers with a similar size as Idaho purchase stop-loss. This is because, from a financial risk and budgetary standpoint, they are comfortable with the impact that a $2 million claim has on their overall budget, knowing that three-quarters of the time, the insurance company would benefit from the employer paying for a stop-loss.

Co-chair Lakey inquired why most state governments go without a stop-loss while county and city governments overwhelmingly purchase stop-loss insurance. Mr. White responded that it was a factor of size since state governments are larger and are more capable of absorbing claims when compared to county or city governments.

The committee recessed for lunch break at 11:59 a.m.

The committee reconvened from lunch break at 1:18 p.m.

Ms. Stayner guided the committee to slide 28 to discuss how medical, dental and vision plans can be funded with a fully-insured model, self-funded model or a hybrid model. In a self-funded environment, an employer typically saves 4%-9%. The State of Idaho would become its own fiduciary, although there are carriers that would take a portion, or all, of the fiduciary liability. As an employer, the State would assume all the risk and pay all of its own claims. She reminded the committee that stop-loss insurance does help mitigate risk. Ms. Stayner guided the committee to slide 32 where it listed several reasons for the state to self-fund and slide 33 delineated both pros and cons to self-funding. She emphasized that claims would fluctuate from month to month.

She explained that in a self-funded program, premium equivalents are still calculated for the following reasons:

- Basis for setting employee contributions;
- Basis for projcting total plan costs/setting budgets; and
- Required to set COBRA rates.

Ms. Stayner proceeded to the self-funding overview on slide 36. Mr. White referred to slide 31 and spoke to the self-funded, self-insured with stop-loss column and stated that while there was a claim margin cost component, it was at the employer's discretion. He explained that, under a self-funded model, an employer would be liable for claims, and some employers like to take a conservative approach and include an explicit margin component in the development of the accrual rates so that at the end of the year, it increases the likelihood that the employers have a positive budget scenario.

Senator Johnson inquired further about the margin component in a self-funded model. Mr. White clarified that the margin will sometimes come into play in a fully-insured arrangement where the employer pays a premium, and if the claims come in below, the carrier gains; in this scenario, a margin is typically not seen. When a potential for a refund is introduced to the employer in a fully-insured arrangement, a margin (risk-charge) is typically added because the employer is paying an additional premium for the additional risk the carrier is taking. In a self-funded environment, an employer might take a more conservative fiscal approach and build a margin in the budget rates developed for the self-funded plan to increase the likelihood that actual costs come below projected; this is at the employer's discretion. He reminded the committee that the State's expected claims are fairly predictable.

Ms. Stayner proceeded to slide 37 to discuss factors driving rising costs of healthcare premiums. She stated that leveraged trend reflects the impact of maintaining the same individual deductible from one plan year to the next after accounting for the underlying medical trends on claims. Most stop loss carriers will reference leveraged trend as the primary reason for the renewal increase on a given case. Leveraged trend supports increasing the individual deductible every two to three years; otherwise the employer is purchasing more stop-loss relative to the total expected claims. She proceeded to slide 40 to describe the difference between specific stop-loss and aggregate stop-loss.

Specific Stop-loss:

- Limits employer's claim exposure for benefits paid on behalf of any covered claimant during the year;
- Deductibles vary based upon the size of the group and expected claims projections; and
- Minimizes risks further; individual deductibles can be low ($75,000-150,000 per person, per year).

Aggregate Stop-loss:

- Limits employer's overall liability for total claims within the term of the contract;
- Based upon expected claims plus a corridor; and
- Can include a monthly maximum exposure feature to limit employer's exposure.

Mr. White referred to slide 41 and explained that, if the State chose to self-fund, stop-loss is an area fraught with exposure to unexpected gaps in coverage, but there are several options to cover these gaps with appropriate insurance. Ms. Stayner briefly listed the self-funding compliance considerations on slide 43 for the committee to review.

Representative Anderson referred to slide 33 and asked what was meant by 'profits to employer' under the 'Pros' column. Ms. Stayner responded that the term was directed to the State's ability to hold its own reserves. From a cash-flow point of view, she said, in a self-funded plan the State would pay for the cost of administration, possibly stop-loss insurance and other expenses if needed. However, it would only pay for claims incurred - not a premium; this allows the State more flexibility with its cash-flow. Mr. White explained that the approach in a fully-insured premium rate was more conservative, which leads to a greater likelihood of the carrier profiting than the employer. If an employer moved from a fully-insured environment to a self-funded environment,

the conservatism would be removed from the underwriting process and this alone would produce positive cash-flow for the employer.

Representative Anderson asked if the State's ability to make claim decisions in a self-funded model would be materially different than Blue Cross of Idaho's ability to do so. Mr. White responded that it would depend on the employer; some employers appreciate the flexibility to make exceptions. He explained that, while summary plan descriptions and open enrollment guides exist, they do not spell out every detail of medical coverage and there is much grey area in the delivery of healthcare.

Representative Anderson inquired whether an employer would have the latitude to be generous in some cases and not in other cases, and if so, would it invite the risk of discrimination. Mr. White responded that it was a valid concern; any time there is deviation from what the carrier has determined, an employer is potentially setting a precedent, which is a consideration for an employer. Ms. Stayner added that, if an employer made an exception for a new procedure, they recommended amending the plan to include the procedure going forward so that it's not perceived as an exception for an individual.

Co-chair Lakey asked if Mercer could explain the pros and cons on slide 33 as it pertained to the State's current hybrid model. Mr. White explained that due to the hybrid model, there would not be a reduction in administration and retention costs, but there would be potential savings in the ACA fees. In the State's current arrangement with Blue Cross of Idaho, the State is allowed a great degree of latitude and flexibility around plan design and programs, which is atypical in fully-insured programs. In regards to the state premium tax issue, due to the State's unique situation of being an employer, the State would be in essence paying itself and was not necessarily a pro or con. The rest of the items mostly applied to the State, even in its current hybrid model.

Ms. Stayner stated that, while the State has a fully-insured arrangement, it has mechanisms of a self-funded plan. However, from a tax point of view, it is subject to the fully-insured ACA fees. She added that most employers the size of the State, in a fully-insured arrangement, would not have much flexiblity in their plan design and programs that the State of Idaho was afforded with Blue Cross of Idaho; they could not assure the State that another vendor would allow for such latitude with a fully-insured model.

Representative Manwaring inquired if the last two pros on slide 33 are specific to a self-funded model in general or specific to transitioning from a fully-insured model to a self-funded model. Mr. White responded that it was the latter.

Self-Funding Requirements for Public Sector Employers in Idaho

Ms. Stayner explained that slides 48-49 outline the registration process and ongoing requirements in Chapter 40, Title 41, Idaho Code, and provide the same information on slides 50-51 for Chapter 41, Title 41, Idaho Code. She proceeded to slide 52 and explained that the State of Idaho is required to register in order to comply with Idaho statutes and the Dept. of Insurance's requirements. Ms. Stayner further explained some of the differences between Chapter 40 and Chapter 41, Title 41, Idaho Code. One of the significant differences was related to the reserves and surplus. In Chapter 40, Title 41, Idaho Code, it requires:

- Quarterly adjustment to reserves; and
- Minimum surplus of three months of contributions or 110% of the difference of the aggregate factor + operational costs and expected cost.

Chapter 41, Title 41, Idaho Code, does not have these requirements, but it does require actuarial recognition of the surplus.

Mr. White opined that, while there could potentially be political ramifications if the State exempted itself from Title 41, Idaho Code, from a consultant's perspective, they understand the reason for why States enact oversight legislation for self-funded programs. It's generally associated with the risk of

self-funding since it increases with smaller employer sizes. In the case of an employer the size of the State of Idaho, the financial risk issues are not significant. He opined that the State would probably not need an additional layer of oversight to effectively manage the financial risk of the plan.

Ms. Stayner inquired as to the rationale behind the exemption for counties from Title 41, Idaho Code. Co-chair Wood responded they would request this information from the legislative librarian.

Next Steps

Mr. White reminded the committee that the next meeting was scheduled for October 19, and according to the Statement of Work, Mercer would provide a revised strategic roadmap. They would need feedback regarding the strategy provided, as well as feedback regarding the financial analysis done and whether the committee would like to see any adjustments. In the final meeting, Mercer could build in, with reasonable assumptions, the estimated impacts of some of the items (e.g., telemedicine) discussed as listed on slide 19 and deliver a revised version. Co-chair Wood asked the committee to review the strategic roadmap during the next few days to provide feedback. He suggested that the committee would need to decide at the next meeting whether to self-fund or not. He also opined that if the State decided to self-fund, it should exempt itself from both Chapter 40 and 41, Title 41, Idaho Code, since he did not believe the State needed an oversight committee.

Co-chair Lakey agreed that the committee did need to decide whether to include in their recommendations to self-fund or not. He opined that the concept of self-funding overall provides a benefit to the State, especially given that the current plan has characteristics of a self-funded model. He believes the initial decision to self-fund or not will depend on the net, long-term benefits. He requested more information regarding what the State is currently paying now for stop-loss insurance and what rates it would potentially pay depending on the dollar amount of stop-loss purchased.

Representative Manwaring voiced his reluctance on deciding whether to self-fund or not until they had more information on how to proceed on plan design, etc. He inquired about the impact if the State kept the current [premium] rates for current employees and kept them in their own separate pool. He also inquired about the potential impact of expanding the pool to include state and local employees.

Mr. White explained that when employers introduce choice in plans, they introduce adverse selection. In other words, the plan that appears most favorable attracts the worst risk. If they kept the plan and grandfathered employees, and underwrote it on its own claims, within the first year the premium rates would increase drastically. This would cause the healthiest people of the sick population to leave the plan and premium rates would rise drastically again the following year. At some point the plan would become so prohibitively expensive that no one would be able to afford to buy it, even if an individual saw value in the option.

In regards to expanding the pool, it would depend on the population introduced. If the demographics brought into the pool are similar to the population already covered under the State plan, it would not impact the per employee claims cost. The area where one could potentially see some cost reductions are around the fixed costs. The per employee per month administration fee, for example, would be higher for a smaller group than for a much larger group, but expanding the pool would only potentially reduce this fee by fractions of a percent of the total cost because claims drive the majority of the cost. Mr. White continued to explain that if the State could introduce a healthy population to the pool it would drive costs down, but there would be no incentive for healthy individuals to join since it would cause their own premium rates to increase.

Senator Johnson voiced his interest in surveying the state employees to learn what features of the plan they would want to retain. He also asked Co-chair Wood if it would be appropriate to ask the Office of Group Insurance (OGI) to address some questions from the committee. Co-chair Wood called upon Ms. Jennifer Pike, administrator for the Office of Group Insurance, to address the committee. Senator Johnson asked for any comments that OGI might have regarding the

presentation. Ms. Pike explained that the State's carrier does not keep more than what is needed to pay claims and administrative expenses; what it keeps in incurred but not reported (IBNR) it pays interest on to the State. She affirmed that the State has a significant amount of control over its plan. OGI looks to the State's carrier for innovation, such as other large plans or in the industry. Ms. Pike acknowledged that opportunities to look into change of utilization patterns for employees exist. While the State's current model is very similar to a self-funded model, they do pay ACA fees and premium taxes and the State cannot avoid these fees in its current structure.

Co-chair Wood asked if the State could choose to carve-out the pharmacy and contract it with a different carrier. Ms. Pike responded that the State's consultant is currently exploring whether the State would benefit from this option. Co-chair Wood asked if 96% of providers are eligible under the PPO plan. Ms. Pike responded that she did not have the exact percentage, but conceded that many of the providers are eligible under the PPO plan; this may be attributed, in part, to Idaho's "any willing provider law." Co-chair Wood explained that his question regarding a potential impediment to managing a network, etc. in the state of Idaho, was in reference to Chapter 39, Title 41, Idaho Code, and opined that the chapter was an impediment.

Co-chair Wood inquired about the cost of the coupon program for pharmaceutical benefits to the citizens of the State of Idaho. Ms. Pike responded that she would provide information regarding how much money the State would save if coupon programs were eliminated. Co-chair Lakey requested specific information regarding what flexibility was available under the State's current model. Ms. Pike responded that the State had the flexibility to implement the options listed on pages 57-62. Co-chair Lakey asked if the State had the ability to select among different options or if it was constrained to the partners its carrier had in place. Ms. Pike responded that the State had the ability to direct its provider to find any services as well as the ability to adopt any of the options it chose to.

Senator Patrick inquired about any feedback that OGI had received from state employees about benefits they value and reminded the committee that salary and benefits as a whole needed to balance in a way that the State of Idaho could remain competitive with the private sector. Ms. Pike responded that the Division of Human Resources had engaged with Milliman to conduct a compensation survey of Idaho that would address the compensation issues. In regards to feedback from employees - it varies significantly depending on the utilization of services.

Representative Anderson inquired whether the State's current plan could be improved. Ms. Pike replied that there were potential areas of improvement in the current plan. Representative Anderson followed up by asking how the committee could assist OGI in this matter. Ms. Pike responded that the education and engagement from the State Employee Group Insurance & Benefits Interim Committee, in discussing the benefits package for state employees, had prompted OGI and the State's carrier to become more engaged in investigating potential ideas. Representative Anderson asked if OGI could make a list of pros and cons that it believes appropriate to the deliberation of the committee as they approach the decision of whether to self-fund or not. Ms. Pike responded in the affirmative.

Senator Johnson commented that the evolution of the State's employee health plan should be a partnership between employees and the State and not a top-down directive. He expressed his belief that together they could compose a better product. Senator Johnson asked Ms. Pike to comment on any potential consequences for the State if it was to forgo its grandfathered status. Ms. Pike responded that there was much less disparity now than there was several years ago between grandfathered plans and nongrandfathered plans. If there was not a big initiative to make the changes that would cause the State to forgo its grandfathered status to add the extra coverages it does not currently have, then maybe it would make more sense to retain the grandfathered status. However, the grandfathered status should not be a constraint or limit the creativity of how the State's employee plan could work.

Representative Manwaring inquired about the cost-advisory tool from Blue Cross of Idaho. Ms. Pike responded that Blue Cross of Idaho launched this transparency tool in January 2017 and they started an education campaign last month around this tool.

Co-chair Lakey requested that OGI provide any calculations to Mercer regarding potential impacts from the potential loss of the grandfathered status.

Mercer reiterated its request for the following meeting:

- Feedback on the roadmap in terms of the strategy and timelines; and
- Feedback on plan designs and employee contributions (increases were not recommendations, but benchmarks based on the market);

Co-chair Wood noted that in Mercer's proposed options for employees, they had removed the traditional plan, and asked if it was their recommendation to discontinue it. Mr. White explained that the rational for discontinuing the traditional plan, was based on the feedback for getting closer to market; Mercer does not look at traditional plans in their surveys as they have become rare to find. He added that 97% of providers participate in the PPO plan, but the traditional plan foregoes the provider discounts in the contract; there is a slight increase in providers available to the employee, but the State is paying considerably more for a slight increase in access.

Co-chair Wood inquired when another option, such as a value-based, direct contract option, could beome available to the State to include as a third option. Mr. White responded that an effective date of July 1, 2019 may be feasible. It would require going through the extensive process of understanding what options are available through the carriers and understanding network access. The decision-making process would include leveraging what the current carrier has in place or contracting directly with an ACO or a patient-centered medical home. Mr. White commented that the third option would not necessarily have to be available in all the counties.

Senator Nye inquired about the percentage of states that are self-funded. Mr. White responded that 89% of states are self-funded.

Co-chair Wood asked the committee to provide Mercer's requested feedback to LSO staff as soon as they could.

After some discussion, the committee agreed to move the October 19 meeting start time to 9:30 a.m. and scheduled another meeting for November 8 to begin at 9:30 a.m. as well.

The meeting adjourned at 3:20 p.m.