MINUTES
Approved by the Committee
State Employee Group Insurance & Benefits Committee
Wednesday, November 08, 2017
9:30 A.M.
Room EW42
Boise, Idaho

Co-chair Todd Lakey called the meeting to order at 9:39 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, Jim Patrick, and Mark Nye; and Representatives Neil Anderson and Robert Anderst. Senator Robert Nonini participated via conference-phone. Absent and excused: Representatives Dustin Manwaring and Hy Kloc. Legislative Services Office (LSO) staff present were: Kristin Ford, Robyn Lockett and Ana Lara.

Other attendees: Sean White, Shelli Stayner, and Carly Debo - Mercer; Representative Lance Clow - Idaho State Legislature; Tim Olson and Norm Varin - Pacific Source; Ryan Fitzgerald - Northwest Credit Union Association; Danielle Rauscher and Scott Jones - Regence Blue Shield; Susan Buxton - Division of Human Resources; Carlie Foster - Lobby Idaho; Jennifer Pike - Office of Group Insurance; Bret Rumbeck, David Jeppesen, Steve Olson, Jill Alessi, Jenn Hoppin, Drew Hobby, and Kelley Carew - Blue Cross of Idaho; Cynthia York, Jeff Crouch, and Casey Moyer - Dept. of Health and Welfare; Jeff Cilek and Sarah Bettmoser - St. Lukes; Marnie Packard - Select Health; Director Dean Cameron, Wes Trexler, Honalee Thomas, and Hermoliva Abejar - Dept. of Insurance; Pat Sullivan - Sullivan and Reberger; Fred Birnbaum - Idaho Freedom Foundation; Karen Thiel - Dept. of Administration; John Keenan - Office of the Attorney General; Audrey Musgrave and Amber Duke - Office of the Idaho State Controller; Nate Piece - St. Luke's Health Partners; and Graham Zickefoose - University of Idaho. Eric Sock from Mercer participated via conference-phone.

Co-chair Lakey called for the approval of the September 21, 2017 minutes. **Co-Chair Wood made a motion to approve the September 21, 2017 minutes. Representative Anderst seconded the motion. The motion passed unanimously.**

Idaho's Statewide Healthcare Innovation Plan (SHIP) - Cynthia York and Casey Moyer, Dept. of Health and Welfare

Co-chair Lakey called on Ms. Cynthia York, SHIP Administrator, and Mr. Casey Moyer, Operations Project Manager, for the Dept. of Health and Welfare (DHW) to begin their presentation. Ms. York provided some historical background with respect to SHIP.

History of SHIP

Idaho had been engaged in efforts to redesign the State's healthcare system for many years. In 2007, Governor Otter created a taskforce of healthcare leaders, healthcare providers, and consumers to find solutions for Idaho's unsustainable and costly healthcare system. The group agreed to implement the patient-centered medical home (PCMH) model. This model incorporated the philosophy of primary care that was patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality and safety.

The group developed a roadmap to improve the healthcare of Idahoans by strengthening primary and preventive care through the PCMH. The PCMH evolved from a fee-for-service, volume-based system of care to a value-based system that rewarded improved healthcare outcomes. In 2013, the State of Idaho was awarded a planning grant to develop SHIP. The stakeholders worked together to identify current system strengths and weaknesses to generate a change based on the continued growth of the PCMH.

In 2014, Governor Otter officially established the Idaho Healthcare Coalition as the advisory group to SHIP. With the guidance and expertise of the coalition, the DHW submitted a SHIP model testing grant proposal to the Centers for Medicare and Medicaid Services (CMMI) and Idaho was awarded a $39.6 million grant. The grant officially began on February 1, 2015, and the first year was considered the pre-implementation year that was dedicated to hiring project staff and contractors. The DHW also recruited its first cohort of 55 primary care clinics and established seven regional collaboratives to support the integration of each PCMH.

In the second year of the SHIP implementation, DHW recruited its second cohort of 55 primary care clinics. To improve rural patient access to PCMH, the virtual PCMH was launched to include:

- Training of community healthworkers and community health emergency services personnel; and
- Integrating telehealth services into rural and frontier practices.

Staffing and Funding

Ms. York informed the committee that the $39.6 million grant DHW had received to operate this initiative was completely federally funded; 96% of the grant was spent on operations and 6% was spent on personnel. The SHIP's staff consisted of 7.6 full-time positions (FTPs). Some of the contracts that it monitored included:

- PCMH transformation and support;
- Idaho Health Data Exchange (IHDE);
- Data analytics; and
- A state evaluation contract.

Patient-Centered Medical Home and Health IT

Additionally, SHIP had subcontracts with Idaho's seven public health districts and supported the Idaho Healthcare Coalition as well. The Idaho Healthcare Coalition identified seven priority goals for SHIP. The PCMH, Health IT, regional collaboratives, and virtual PCMH support Idaho's goal of strengthening primary and preventive care through the PCMH model. The payment reform methodology aligned with Idaho's goal to evolve from a fee-for-service, volume-based system of care to a value-based payment system that rewards improved health outcomes.

The test model included transforming 165 primary care practices across the state into PCMHs. The model also focused on improving care coordination through the utilization of electronic health records and the sharing of health data connections among PCMHs and across the medical health community. The availability of information at a clinic, county, region, and state level was important to monitor progress, outcomes, and the health of the population. To improve the availability of this information, all SHIP cohort clinics were eligible to be connected to the Idaho Health Data Exchange, to which the clinics can access and contribute patient information. SHIP contracted with Health Tech Solutions to use the data within the Idaho Health Data Exchange to produce analytics and outcome measures to support healthcare transformation. There were 109 clinics participating in the PCMH transformation, 50 of which have received national accreditation; this represented the clinics in Cohorts 1 and 2 of the projects.

The SHIP program provided funding to clinics to assist in connecting them to the Idaho Health Data Exchange (IHDE); the costs varied by the EHR vendor, and the type and number of connections needed to achieve bidirectional sharing of data. The IHDE worked daily with clinics to implement the electronic connections; SHIP expected more connections in the following months. Ms. York suggested that the SHIP program had been very successful with the PCMH model adoption process and the collaboration among participating clinics had surpassed its expectations. She opined that a major challenge in the State of Idaho, as with many other states, was multiple health electronic record products that operated on different platforms and created a significant amount of work at a cost to the State or any entity attempting to coordinate data flow. Ms. York posed that another

challenge to the process was physician fatigue; there were multiple, and sometimes conflicting, initiatives in the healthcare arena that provider practices encountered and the participation in varying programs could be confusing and exhausting.

Regional Collaboratives and Virtual PCMH

Ms. York explained that local leadership, knowledge, and action to put the patient at the center of their healthcare was reinforced through the SHIP's regional health collaboratives that were supported by the public health districts. Each district identified its community health needs and worked with its partners to address those needs. She added that extending the reach of the PCMH was also foundational to the SHIP program. Ms. York explained that, by developing community healthworker and community health EMS curricula and supporting training, SHIP was maximizing the workforce statewide. She further explained that telehealth advances to reach physicians in rural areas and Project Extension for Community Healthcare Outcomes (ECHO) through the University of Idaho helped equip Idaho medical professionals to treat patients in their practices; patients who otherwise would have been referred to a specialist.

Ms. York described some of the health district and regional collaboratives projects:

- District 1 Program - focused on developing medical health neighborhood links between community health emergency medical services agencies, hospital discharge planners, and SHIP PCMH.
- District 3 Program - supported the development of care coordination and care management professional networks.
- District 4 Program - supported the role of the caregiver in the PCMH and enhanced resource connectivity within four counties.
- District 6 Program - focused on a three-prong suicide prevention effort that included a suicide prevention symposium held in September to coincide with the national suicide prevention week. It also included regional technical assistance on the use of the Columbia-Suicide Severity Rating Scale and supported Program ChildSafe - a program that promoted gun safety.

Payment Reform

Ms. York explained that providers were making fundamental changes in their day to day operations to improve quality of care and to better coordinate care. These operational changes would be viable and attractive only if new payment reforms were broadly adopted. She stated that Health and Human Services had set a goal of tying 30% of U.S. healthcare payments to quality of value through alternative payments by 2016 and 50% of all U.S. healthcare payments by 2018. According to a report released the previous week, Ms. York said, 29% of healthcare payments in 2016 were in alternative payment model categories that included shared-savings and population-based payments. Idaho's three largest commercial insurers (Blue Cross of Idaho, Regence, and Pacific Source), along with Medicaid, were critical stakeholders in this initiative. The chart on slide 10 depicted the framework assigning the payment from the payer to the healthcare provider into four different categories. This baseline data showed that commercial and Medicare payers in Idaho were beginning to assign beneficiaries to value-based payment arrangements with incentives for providers based on quality and value. GAIN-sharing, risk-sharing, and population-based payments were recently introduced in the Medicare-care and commercial settings. However, payments were still primarily based on fee-for-service.

SHIP's state innovation model (SIM) financial analysis contractor, Mercer, collected aggregates and created the SHIP payer report. Ms. York stated Medicaid had begun incentivizing primary care providers to expand the PCMH model by initiating a tiered-payment program that rewarded improved care coordination and better health outcomes. She explained that Medicaid was in the process of launching Healthy Connections Value-Care, a community-based accountable care program that would cover a broad range of healthcare transformation activities and population-based care management initiatives.

Ms. York stated that SHIP had helped improve the environment with an enhanced care delivery model, allowing for reformed payment mechanisms to begin. She added that PCMHs, health IT interoperability, virtual PCMH, telehealth, and Project ECHO were all Idaho-envisioned elements of the transformed delivery system. She emphasized that, while progress takes time, SHIP had provided resources and system change to Idaho.

Discussion:

Co-chair Wood inquired how many practices and clinics were in the process of converting to PCMHs to qualify for national accreditation of the PCMH, outside of the SHIP program. Ms. York responded that she was unsure of the number. She emphasized that the SHIP program had helped increase the momentum for practices to make strides toward value-based care. Co-chair Wood commented that he anticipated each practice and clinic to make this transformation eventually because that was the direction healthcare was headed.

Senator Patrick inquired how well the program would work without federal funding and how much it would cost the State without federal funding. Ms. York responded that the $39 million that SHIP received was federal funds. However, the Idaho Healthcare Coalition and other stakeholders had stated that they would continue down this path, regardless of federal funding. She was not sure how much it would cost the State to continue to educate, inform, and provide the resources to primary care practices.

Co-chair Lakey inquired about the transformation of a primary care practice in regards to its day to day operations. Ms. York explained that one example would be a primary care practice creating a team where each person works at the highest-level of licensure. Another example of coordination of care could include integrating a mental health provider within the practice. Mr. Moyer explained that in addition to it being team-based care, it's also more proactive when it comes to healthcare. The clinics and practices may use registries for patients with certain levels of disease to engage with patients and actively support them. He emphasized that it was vital for patients and providers to work together to effectively manage disease states or prevent disease altogether to bend the cost curve and transform the way healthcare is delivered. He explained that some of the resources that the SHIP program provided included technical assistance contractors that meet with clinics to discuss workflow, quality improvement, the use of registries, and how to effectively leverage electronic health information data to be predictive in managing healthcare populations. He added that each clinic develops its own transformation program with the help of the technical assistance contractors provided by SHIP.

Co-chair Lakey inquired about value-based outcome metrics, how they were developed, and how it had been successful. Mr. Moyer responded that the SHIP program had a catalog of 16 clinical quality metrics, that were also national metrics, and its goal was to align those metrics with other reporting structures. He explained that SHIP was using health tech solutions to draw the data from the data exchange and provide it to the clinics, as well as to produce the data at a community level. He added that one of the challenges was the level of connectivity they had been able to achieve thus far; only 59 of the 109 organizations were connected to transform and develop data. Co-chair Lakey inquired about some examples of the metrics. Mr. Moyer responded that IHC would be meeting in the afternoon to review the final four metrics that were chosen. Some of the examples included:

- Tobacco Cessation - Screening and Cessation Intervention;
- Weight Measurement and Counseling for Nutrition and Physical Activity for Children and Adolescents;
- BMI Screening; and
- Diabetes Care.

Co-chair Lakey inquired how the compensation to clinics and practices was different based on the metrics chosen. Ms. York responded that compensation was still done based on fee-for-service. However, value-based care payment system would require providers to be paid based on metric

outcomes. Mr. Moyer explained that SHIP was attempting to prove a concept to influence the market to use the benchmarks and to transition to a value-based care payment system. Senator Patrick inquired about cash-flow issues that could arise from transitioning to a value-based care payment system with respect to metric outcomes, especially given that patients often do not adhere to their physician's recommendations. Mr. Moyer opined that the industry did have tools (e.g., shared savings) that would assist providers with any potential cash-flow issues that could arise before outcomes could be measured and compensated accordingly.

Blue Cross Program Offerings and Opportunities - Dave Jeppesen and Drew Hobby, Blue Cross of Idaho

Co-chair Lakey called upon Mr. Dave Jeppesen, Executive Vice President of Consumer Healthcare, and Drew Hobby, Vice President of Provider Network Management, for Blue Cross of Idaho (BCI), to present. Mr. Jeppesen began his presentation by delineating his presentation points:

- The State's hybrid model;
- Reduction of healthcare spending; and
- Cost-effective, quality programs.

Explanation of the Hybrid Model

Mr. Jeppesen described the State's hybrid model as a unique, Idaho-based solution that had been used for several years. He explained that, through actuarial science, a premium is set for the fiscal year. The premium is collected by Blue Cross of Idaho as the State's plan administrator. As claims are incurred, BCI pays the claims on behalf of the State of Idaho. On a monthly basis, BCI reviews the claims paid versus the premium, and if the claims paid are less than the premium, BCI transfers funds (with interest) to the State of Idaho. If the opposite is true, then a payment is owed to BCI to settle the difference. He further explained that in the hybrid model, BCI requires a reserve based on the predicted claims amount plus 10%. If any claims are incurred above the 110% reserve, BCI then covers any claims above the reserve amount.

Representative Anderson inquired how BCI was compensated. Mr. Jeppesen explained that BCI's actuarial predications are fairly accurate, but if the State of Idaho's claims were to exceed the 110% reserve, BCI would be compensated indirectly through its administrative fee.

Mr. Jeppesen proceeded to contrast the State's hybrid model with a self-funded model. The differences were:

- There would be no monthly settlement;
- Claims incurred would be paid by BCI; and
- The State of Idaho would reimburse BCI on the claims paid on its behalf.

Mr. Jeppesen further explained that, in the case of a fully-insured model, the process would be:

- There would be no monthly settlement;
- BCI would set a premium based on actuarial science;
- BCI pays the claims; and
- BCI incurs the risk based on its claims prediction.

Senator Patrick inquired how reserve funds were held in a self-funded model. Mr. Jeppesen responded that, similar to the State's hybrid model, the reserves were held by the self-funded entity. The difference was that, in the event the State transitioned to a self-funded model, a trust would need to be created to hold the reserve.

Mr. Jeppesen proceeded to slide 4 and opined that the hybrid model provided the most benefits for the State. The benefits for the State to keep its current hybrid model included:

- Full control of plan design;

- Overpayment settlement with interest in monthly reconciliation;
- Operating costs were lower;
- Financial liability risk was limited;
- Public exposure risk was limited;
- Control and accessibility to settlement funds;
- No "trust" expense; and
- Protection as a fully-insured plan.

Mr. Jeppesen stated that Milliman had predicted a $2.7 million increase in cost over a three-year span if the State was to transition to a self-funded model. Co-chair Wood commented that Ada County was exempted from Chapter 40, Title 41, Idaho Code, and did not pay many regulatory costs. He asked if Milliman had taken the possiblity of the State exempting itself from that section in Idaho Code when it produced its estimation. Mr. Jeppesen was unsure and stated he would follow up with Milliman, but he cautioned that not all of the potential fees were dependent on the State's exempting itself or not from Chapter 40, Title 41, Idaho Code.

Mr. Jeppesen explained that in the hybrid model, the carrier (BCI) makes claims decisions; in a self-funded model, the responsibility falls upon the self-funded plan. Co-chair Lakey asked if the State could hire a third-party administrator to take on the fiduciary responsibility. Mr. Jeppesen responded in the affirmative, but it would come at a cost. Representative Anderst asked, with respect to plan design, if there was anything that could be done with a self-funded model that couldn't be done with the current hybrid model. Mr. Jeppesen responded that, with respect to plan design, anything that could be done in a self-funded model could also be done in a hybrid model.

Representative Anderson asked if the list provided on slide 4 was the exhaustive list for the committee to take into account to make its decision whether to retain the current hybrid model or transition to a self-funded model. Mr. Jeppesen responded in the affirmative. Representative Anderson summarized his understanding of BCI's stated advantages for the State to keeps its hybrid model:

- Both the self-model and hybrid model allow the State to control its plan;
- The State would still collect interest in a self-funded model - although it may be in a separate fund;
- Inquired about the difference in cost, given BCI's earlier statement that operating costs would be "lower" in a hybrid model;
- The State had never exceeded the 110% reserve and it could purchase stop-loss if it was concerned about potentially exceeding it;
- Suggested that the Legislature would provide some funding to the trust each year in anticipation of claims to be paid; any funds accrued within the trust would mitigate the amount of funding needed for the succeeding year; and
- Was under the impression that the State paid $10 million in ACA fees each year and was unsure what exact amount was paid to BCI to administer the plan; he estimated the administrative fee to be about $10 million a year.

Mr. Jeppesen commented that the operating cost would increase by $2.7 million over a three-year spans, but recognized that exempting the State from Chapter 40, Title 41, Idaho Code, would change that cost. He cautioned the committee not to underestimate the potential for an entity to surpass its reserve or savings. He added that, although the State had never surpassed the 110% reserve, it had surpassed 100% of its reserve in a recent year. Mr. Jeppesen stated that the State's level of control with respect to its claim funds would be different in a self-funded model since the funding would be kept in a trust and managed by independent trustees. Senator Patrick asked if the State would lose its grandfathered status if it transitioned to a self-funded model. Mr. Jeppesen responded in the negative.

Current Hybrid Arrangement

Mr. Jeppesen explained that, for every premium dollar:

- 91.9 cents was applied to claims and was further divided in the following manner:
    - 73.6 cents for medical claims; and
    - 18.3 cents for prescriptions.
- 8.1 cents was provided to BCI and was further divided in the following manner:
    - 3.4 cents for the administrative fee;
    - 1.5 cents for the ID premium fee; and
    - 3.2 cents for the federal (HIT) tax.

Mr. Jeppesen explained that, when comparing Fiscal Year (FY) 2016 and FY2017, there was a reduction in both medical and dental claims. He added that while pharmacy costs had increased, it had not done so at the rate seen in other market places. The premium returned to the State, with interest, was $6.3 million. Mr. Jeppesen suggested that it had revamped the State's contract with the pharmacy benefit manager (PBM) and it resulted in higher rebates at a lower cost for generic drugs; it also affected how the pharmacy drugs were administered in the plan. In addition to this, Mr. Jeppesen said, BCI provided the State with clinical oversight services that monitored and ensured that services were delivered in quality settings at the lowest cost possible. Mr. Jeppesen stated that BCI had introduced payment innovations (e.g., value-based models) into the Idaho marketplace and suggested that the reduction in claims could be attributed to the active work BCI had done in partnership with the State.

Representative Anderst asked BCI about the process for developing the the State's plan and benefits package and whether anything could be done to improve the process' effectiveness. Mr. Jeppesen explained that the process included BCI monitoring the State's data regularly, working with the State's actuary consultant, and meeting with the Dept. of Administration to discuss its findings and recommendations. He added that it was BCI's commitment to be even more proactive and strategic in administering the State's plan.

Value-Driven Care

Mr. Hobby stated that value-based care was a strategic priority for BCI and suggested it was the leader for value-based care in the State of Idaho. He noted that BCI:

- Created different provider reimbursement mechanisms that are tied to paying for higher-quality and more efficient care; and
- Invested heavily in delivering data, technology, tools, and resources to providers.

He described some of BCI's programs and the direction it was headed:

- 100% of BCI's commercial fee schedule is tied to efficient delivery of care;
- Deployed narrow network strategies with some of its commercial customers. He explained that providers were accountable to deliver care at a lower cost, but a higher quality as well;
- Applied some bundled-payment methodologies; and
- Shared-savings programs.

Representative Anderst asked for an example of a shared-savings program. Mr. Hobby explained that BCI had a tool that measured how efficient providers were with respect to episodes of care (ER visitation, independent imaging, etc.) and the physicians rate of reimbursement was dependent on how they performed when compared to their peers.

Senator Patrick inquired about what Mr. Hobby meant by efficiency. Mr. Hobby emphasized that BCI did not want to incentivize poor care for the sake of efficiency. He explained that BCI looked to each physician's total cost of care for an episode of care. He added that BCI was responsible for ensuring that its customer receive the best value for care. Senator Patrick emphasized the importance for physicians to have pharmaceutical data, particularly costs, available to them. Mr.

Steve Olson, Director of Pharmacy at BCI, explained that pharmacy costs had increased yearly and one of the components for this was transparency. He emphasized that increasing the transparency of medication costs at the point of service was important.

Co-chair Wood inquired about BCI's partnerships in terms of providers. Mr. Hobby responded that BCI had identified provider partners that specifically aligned to the State of Idaho's membership across the state. Co-chair Wood asked if BCI had any models where the healthcare delivery system assumed 100% of the liability and the carrier assumed no liability. He also inquired about the payment models used by BCI. Mr. Hobby responded that the underlying reimbursement for the shared-savings program was still fee-for-service. BCI also had a profit and loss (P&L) income statement process and made available to healthcare providers an opportunity to receive a surplus reimbursement on a regularly scheduled basis, depending on the P&L income statement and the healthcare targets. With respect to commercial shared-savings arrangements, BCI did not offer models without downside risk.

Value-Based Care Savings

Mr. Hobby proceeded to slide 8 and presented the committee with a value-based, shared-savings arrangement that BCI proposed to move the State to in 2018. He explained that the 11,000 number represented employees and their dependents who had visited a primary care physician, within the last 18 months, in any of the seven different provider systems across the state. He explained that if BCI incorporated the State employee group into the shared-savings commercial PPO shared-savings programs, which has a trend target, the State could save $1.8 million in FY2019. BCI would then set the trend target higher and save the State an estimated $3.9 million in the second year (FY2020). He explained that many of the payment arrangements were three-year arrangements where the arrangement begins with shared-savings upside-only; but by year 2 or year 3 it transitions to downside-risk. Senator Johnson inquired whether this same strategy could be used by the State when designing its request for proposal (RFP) for a third-party administrator (TPA) to ensure competition and incentivize the TPA to meet certain objectives. Mr. Hobby responded in the affirmative.

Representative Anderson inquired whether the patient would notice any change of arrangements. Mr. Hobby responded that the change could be transparent, but the State could certainly choose to make the patients aware. Representative Anderson asked if the providers' compensation would decrease by $4 million if the State was to save $4 million FY2020. Mr. Hobby responded in the negative. He explained that patients would receive more efficient care that would produce savings. Representative Anderson inquired whether those efficiencies would also reduce the income to the institution as well as the expenses. Mr. Hobby responded that there could be a decrease in services to certain institutions and certain provider types in order to apply the appropriate delivery care to patients to aid in lowering the total cost of care.

Mr. Hobby emphasized that BCI did have quality programs embedded within its payment arrangements. He explained that each payment arrangement has quality metrics around a variety of preventive measures (e.g., diabetes, wellness child visits, preventative screenings) and readmission rates and ER utilization. If a provider performed better than the trend, the provider would also have to meet quality standards expected by BCI; if those quality metrics were not met, BCI would decrease the surplus paid to the provider.

Committee and Consultant Discussion Period with Blue Cross of Idaho

Co-chair Wood inquired whether BCI would be able to support the State of Idaho, as the contractor, if it was to leverage the SHIP program into a value-based option for State employees. Mr. Jeppesen responded in the affirmative. Co-chair Wood inquired whether the State would lose its grandfathered status if it were to transition from a fully-insured model to a self-funded model. Mr. Weston Trexler, Bureau Chief for the Dept. of Insurance, responded that, as long as the benefit design stayed within the parameters of what was required to maintain the grandfathered status,

the State could transition to a self-funded model and retain its grandfathered status. Ms. Stayner and Mr. Jeppeson concurred with Mr. Trexler.

Mr. White observed that for an organization the size of the State of Idaho to not have a self-funded model was unusual and opined that the claims were fairly predictable. Mr. White asked, especially given that the State had never exceeded its 110% reserve, whether BCI would have made a similar recommendation to another organization regarding the hybrid model. Mr. Jeppesen responded that it would depend on the organization's specific needs. He opined that the hybrid model was the best model for the State. Mr. White asked, if the State had never exceeded its reserve, what financial benefit did it have to retain its hybrid model. Mr. Jeppesen responded that transitioning to a self-funded model could require the State to incur many incremental costs that could outweigh the costs and benefits to retaining its hybrid model.

Mr. Sock, in reference to slides 4 and 5, asked if the State accrued any cost to BCI for the stop-loss insurance it provided in the event that the State's claims were to exceed its reserve. Mr. Jeppesen responded that there was a cost to the State for BCI to take on the additional risk and that fee was included in its administrative fee. Mr. Sock suggested that it would be of interest to see what portion of the administrative fee was attributed to BCI taking on this additional risk, as well as its operating costs. Mr. Sock opined that the 3.4% rate for its administrative fee was competitive and inquired whether it included the stop-loss fee and operational costs. He also asked if BCI received any additional reimbursements outside of the 3.4% administrative fee. Mr. Jeppesen responded that BCI's only reimbursement was the 3.4% administrative fee, which included both the operational costs and the stop-loss fee. Mr. Sock inquired whether BCI earned interest on the State's funds at any point during the monthly claim reconciliation process. Mr. Jeppesen explained that BCI was a not-for-profit mutual insurance company and that it operated in a manner to benefit the policy holders. He responded that Mr. Jeppesen did not invest the State's funds to create a spread between BCI's investment and the Treasury interest paid to the State of Idaho.

Mr. White asked whether the State's current hybrid structure allowed for it to:

- Partner with external vendors with respect to telemedicine;
- Set up centers of excellence;
- Set up near-site clinics; or
- Carve out pharmacy.

Mr. Jeppesen responded in the affirmative and added that the State would need to decide whether it would administer the various contracts or if it would prefer the carrier to do so. Ms. Stayner asked if BCI assigned a pooling point for large claims and, if so, was there a cost involved with the pooling point. She suggested that, if BCI had not assigned a pooling point to the State of Idaho, it should do so to limit total exposure. Mr. Jeppesen reiterated his caution against underestimating the risk of high-dollar claims. He explained that BCI had strategies in place to manage the risk associated with all accounts to which it provides stop-loss insurance. Ms. Stayner inquired again whether there was a pooling point included in the underwriting process with the State. Mr. Jeppeson stated that he was unsure, but that he would provide the response at a later date to the co-chairs.

Representative Anderson inquired whether the State's $10 million ACA fees had been waived in the current year and for the next year based on the current federal laws. Mr. Jeppeson explained that the HIT (Health Insurance Tax) Tax, about $10 million for the State of Idaho, had been waived for the year 2017, but was not waived for the year 2018 and was currently being collected as part of the premium process.

Co-chair Lakey inquired about the $13 million fee that was included in the committee's materials. Ms. Lockett referred to Milliman's most recent actuarial report for the State, dated November 6, 2017, and made the following points:

- The projected FY2019 administrative cost for BCI was $10,040, which is equivalent to the 3.4%;

- In FY2017, the healthcare reform fees totaled just over $1.8 million;
- In FY2018, the healthcare reform fees totaled just over $9 million; and
- For FY2019, the healthcare reform fees were about $9.7 million.

Representative Anderst inquired about the difference in cost for the healthcare reform fees between FY2017 and FY2018. Mr. Lockett responded that there was a moratorium on the fees, which accounted for the reduction in the healthcare reform fees for FY2017. Mr. Anderson asked if the healthcare reform fees would be negated if the State transitioned to a self-funded model. Mr. White responded that if the State converted to a self-funded model, it would not pay the ACA fees; the ACA fees only apply to a fully-insured model.

Senator Nonini asked, if the State were to convert to a self-funded model, would it be successful in contracting a TPA with an administrative fee of 3.4%. Mr. White responded that the administrative fee component in the hyrbid model was competitive and consistent with what Mercer would expect the State to achieve in a self-funded arrangement. He added that if the State chose to purchase stop-loss insurance it would come at an additional cost, but it would not be required to pay the Premium Tax and the ACA fees.

The committee adjourned for a lunch break at 12:02 p.m.

The committee reconvened at 1:28 p.m.

Committee and Consultant Discussion Period with Blue Cross of Idaho (Continued)

Co-chair Lakey referred to BCI's delineated items that were 'optional with additional cost,' and asked how any additional costs would be accessed and if the cost varied by type. Mr. Jeppeson responded that there would be some variation on how a potential additional cost would be charged. He explained that some would be charged as administrative fees to administer programs and others would be considered access fees. He further explained that, in the case of centers of excellence, BCI would tap into centers of excellence around the state for diagnoses, etc., and would then assess an additional fee, typically a flat fee, on the claim. Co-chair Lakey inquired about the first column of the second page of BCI's handout. Mr. Jeppeson responded that the first column described whether the service or item was currently included in the State's plan. Co-chair Lakey asked if the State would need to amend its current agreement with BCI if it were to include an additional service or item. Mr. Jeppesen responded that the master contract would not necessarily need to be modified, but an amendment pertaining to that service would be. He explained that, depending on the additional service or item, it may or may not necessitate a change to the overall benefit design. Mr. Jeppesen clarified that the last column designated whether, in a self-funded model, the State's program would include the service or item, as well as the potential for it to be offered at an additional cost.

Senator Patrick inquired about the process for amending the State's contract with BCI. Mr. Jeppesen responded that the Dept. of Administration was responsible for administering the health benefits contract. Ms. Jennifer Pike, Administrator for the Office of Group Insurance, explained that by statute the Director of the Dept. of Administration had the ability to negotiate for benefits on behalf of state employees. However, the department worked with the Group Insurance Advisory Committee, its statutory advisory committee, and did draw feedback from not only the advisory committee, but from a variety of sources (e.g., germane committees, Joint Finance-Appropriations Committee, and Change in Employee Compensation Committee).

Senator Johnson inquired how many BCI employer groups used centers of excellence, value-based care programs, etc. Mr. Jeppeson responded that value-based contracting was incorporated in all of BCI's fully-insured accounts and would be applied to a hybrid or self-funded group, on a group by group basis. In the case of value-based contracting with respect to fee schedules for physicians, it is applied to both self-funded and fully-insured groups. With respect to the other items, Mr. Jeppesen did not have that information on hand, but could produce the data at a later date. Senator Johnson asked BCI to address the contract's performance and guarantees. Senator Johnson suggested that

there didn't seem to be many contract violations and inquired about the contract's enforcement and audit processes. Mr. Jeppesen emphasized BCI's commitment to its clients. He explained that guarantees are validated and reported by BCI's internal audit department, and periodically its clients would have independent auditors review and validate that the performance guarantees were being met. He suggested that BCI performed well in meeting its performance guarantees.

Representative Anderson inquired about the 11,000 members described on slide 8 of the presentation. Mr. Hobby explained BCI attributed 11,000 members and/or dependents, that had seen a primary care physician in the last 12 to 18 months, to seven provider groups with which it had existing commercial value-based care arrangements. Representative Anderson inquired whether, with the passage of time, the number of members and dependents visiting primary care physicians would increase. Mr. Hobby responded in the affirmative and expressed BCI's desire to increase the alignment of the State's heath plan membership to primary care physicians. Representative Anderson inquired about the State's current non-qualified, high-deductible health plan (HDHP) and whose responsibility it was to make it a [health savings account (HSA)] qualified HDHP. Mr. Jeppesen explained that there were federal requirements that determined whether a HDHP plan qualifies for an HSA and it would be up to the State to determine whether it would want to proceed with converting it to a HSA qualified, HDHP plan; BCI could administer the plan in either form. Representative Anderson asked, with respect to BCI's comments regarding it being a not-for-profit mutual insurance provider and Mr. Sock's comments with respect to BCI's competitive administrative fee of 3.4%, what was BCI's profit margin with respect to administering the State's health plan. Mr. Jeppesen reiterated that, as a not-for-profit, mutual insurance company, its goal was not to produce high margins [of profits], but to cover its costs.

Representative Anderson referred to slide 10 of BCI's presentation and inquired about the five 'not recommended' items - specifically why BCI did not recommend pursuing those items (i.e., tobacco surcharge, spousal surcharge, salary-based strategies, etc.). Mr. Jeppesen responded that BCI would be amenable to exploring the 'recommended' programs in the future. He explained that the current model offered the flexibility to explore those programs. He described two reasons for BCI's 'not recommended' stance to the five items listed on slide 10:

1. Outside the purview of the services that BCI provides the State; and
2. Offer incentive-based options rather than penalties to achieve the same outcome (e.g., tobacco cessation).

Co-chair Lakey inquired about potential incentive-based options. Mr. Jeppesen explained that employers had better luck offering an incentive for employees to participate in tobacco cessation programs rather than simply collecting a tobacco surcharge.

Ms. Stayner inquired whether all the potential options discussed (e.g., expert medical opinion) could be set in place by BCI by July 2019. Mr. Jeppesen responded in the affirmative.

Co-chair Wood asked, with respect to value-based care, at what point in time BCI would develop capitated products where eventually the entire financial liability would rest with the healthcare delivery. Mr. Jeppesen explained that there was a spectrum of maturity in the provider community with respect to its ability to do it and that there was a different skill set involved to achieve this. He added that some systems were prepared and ready to take more risk and BCI would move quickly to the appropriate level of risk for the product. He also said that with the systems and providers that were not ready to take on this risk, BCI would work with them to make the process successful.

Co-chair Wood asked why BCI would not recommend potentially integrating the State employee population into Medicaid with the Medicaid fee schedule or reimbursement level. Mr. Jeppesen stated that this area was beyond the scope of what BCI could advise. He explained that it was BCI's opinion that it would be a very different benefit program and create a significant disruptive change for employees and their dependents. The other issue was that it would potentially cause many provider systems in the market not to participate in this type of arrangement; most provider

systems believe that they break even, at best, in accepting Medicaid and Medicare reimbursement rates. Co-chair Wood inquired whether BCI would still hold to this opinion if the fee schedule for State employees was different from the Medicaid fee schedule. He described the arrangement as potentially adopting SHIP's value-based care model and pursuing PCMHs. Mr. Jeppesen responded that, with respect to a network model of value-based care, BCI was interested in participating in this arrangement.

Mercer Presentation - Shelli Stayner, Sean White, and Carly Debo - Mercer

Co-chair Lakey called upon Mercer to present. Mr. White briefly summarized the agenda on slide 2 of Mercer's presentation. He proceeded to slide 4 and described the committee's feedback, classified into four categories. He summarized the feedback summary with respect to the four categories: care delivery, workforce health, program design, and delivery infrastructure. Mr. White stated that, if there was an incentive tied to a health condition, there would need to be a reasonable alternative standard to meet it. He explained that, with respect to a tobacco surcharge, it is usually done through affidavit. An employee, usually at the time of open enrollment, would have three options to choose from:

1. Not a tobacco user;
2. Used tobacco in the last 6, 9 or 12 months, but agrees to participate in a tobacco cessation program - no surcharge collected; or
3. Tobacco user and refuses to participate in a cessation program - surcharge applies.

Mr. White proceeded to address the concerns with respect to the level of increase and cost-shift, both from a plan design standpoint and from an employee contribution standpoint. He reminded the committee that the financial model presented at the last meeting illustrated what the State of Idaho plan would look like if it wanted to reach the market benchmarks. He added that it was not a recommendation for what the State should do in the first year of transition, but a starting point for discussion. Mercer recognized that making that much of an increase in a single year would be significant and would create a difficult change in the management process. If the ultimate goal was to reach market levels, it would be more appropriate to phase those increases in over multiple years.

Mr. White stated that there was general support for the concept for salary based approaches, but there were some questions whether it should be done through contributions to a savings account versus payroll deductions.

Mr. White described the process for spousal surcharge as similar to a tobacco surcharge process. He explained that an employee, typically at enrollment, would complete an affidavit stating one of the following:

1. I'm covering my spouse and he/she does not have access to other employer-sponsored coverage - surcharge does not apply; or
2. I'm covering my spouse who does have access to employer-sponsored coverage - surcharge applies.

Senator Patrick asked how the State's employee costs compared with other states and employers. Mr. White responded that Mercer had data in its survey of what the State's program average cost was compared to other states's program average costs and could provide it as a follow-up.

Senator Nye inquired whether Mercer's scope of work was completed. Mr. White responded that, under the statement of work that was signed by the committee, it was Mercer's final meeting, but it was hopeful to continue the dialogue and partnership. Senator Nye thanked Mercer for its work.

Mr. White summarized slides 6-9 as an outline for the guiding principles provided to the committee earlier in the interim and described the approach that Mercer took to develop its strategy.

Mr. White proceeded to slide 10 and reminded the committee that it was the detailed strategic roadmap that was put together based on the committee's feedback. He explained that the only

significant change made to the roadmap since the last meeting was the addition for exploring the possibility of leveraging the SHIP program.

Mr. White proceeded to slide 13 and explained that Mercer had included more specific savings that the State could benefit from. The considerations for optimizing savings was presented at the last meeting, but Mercer added some dollar figures to benefit future conversations with respect to this topic.

Representative Anderson inquired whether the savings would be annual savings or one-time savings. Mr. White responded that Mercer believed that the State had the potential to achieve these savings on an annual basis. He reminded the committee that while the individual potential savings looked significant, each item was a considerably small percentage of what the State spent on its total healthcare.

Co-chair Wood asked how long the process could be to achieve a mature value-based care system. Mr. White explained that it would depend on:

- Level of access;
- Readiness of provider groups and how quickly they can change their delivery practice patterns; and
- How aggressive the State as the employer becomes in creating a structure and incentives within its program to drive employees and their dependents to these types of arrangements.

Co-chair Wood asked if the process would take, at a minimum, a few years. Mr. White responded in the affirmative.

Ms. Stayner reiterated that the rational for BCI's presence at the meeting was to obtain possible timelines for the potential additional features or programs the State was considering. She reminded the committee that Mercer's belief that self-funding, embracing disruption, and paying for value was important for the State of Idaho and that the State had a unique opportunity to be a "driver" for what happens in the marketplace. Ms. Stayner explained that, based on Mercer's findings, it recommended that the State of Idaho proceed with self-funding. Its recommendation was driven by the potential savings and the necessary flexibility needed for the implementation of future plan and cost management strategies.

Co-chair Wood noted his appreciation to BCI for presenting to the committee and answering questions from both the committee and its consultant. He explained that the committee was struggling to find answers because it understood that its actions, if done incorrectly, could impact employees in a negative way. He suggested that the State should write a new request for proposal (RFP) and stated that it was up to the State, as the employer, to determine what should be included in the contract. He explained that if the State chose to self-fund, the State could include a variety of duties for a TPA, and the contract would not necessarily be different from its current form. Ms. Stayner and Mr. White agreed. Mr. White commented that the State would have the flexibility to maintain as much external control through the TPA as it desired. In fact, he said, if the State chose to stay with BCI, the State could have BCI continue to do all the services it does today. However, in a self-funded environment, the State did have the option to become the final arbiter in an appeal situation, but the State could outsource the fiduciary responsibility as well; typically for less than a dollar per employee per month.

Representative Anderson inquired whether the State could still do most of those same things, put out a new RFP, and retain its current funding model. Mr. White responded in the affirmative. He stated that Mercer could not promise, if the State chose to pursue different carriers, that they would be similarly agreeable under a fully-insured or hybrid model. However, in a self-funded model, Mercer could guarantee that other carriers would be agreeable.

Co-chair Lakey asked Mercer to reiterate the reasons why self-funding was in the best interest of the State. Ms. Stayner stated that the flexibility that BCI afforded the State was agreeable, but the flexibility and initiative that self-funding could provide the State would be beneficial and could even

make it a driver in the State. Mr. White stated that, in listening to the discussions regarding the value provided by the hybrid arrangement and BCI's comments with respect to the risk level the State could expose itself to in moving away from its current model, the fact that the State had never exceeded its reserve of 110% suggested there wasn't much risk that the State was protecting against. He stated that while the State had exceeded 100% of the reserve in the past, the State paid those claims and would continue paying those claims in a self-funded arrangement. The State would also have the benefit of cash-flow from a timing standpoint given the delay before the reimbursement takes place. Mr. White explained that even though the current hybrid arrangement was flexible, the self-funding model afforded the State the most flexibility in the long term and future; and if the State chose to work with another vendor partner, it would ensure that the State had the flexibility to pursue its strategy going forward.

Senator Patrick explained that, under a self-funded model, the State would have its reserve in a trust account that would be administered by another agency. He stated his concern that this model would not afford the State its current cash-flow flexibility. Mr. White asked if the trust was a requirement for the State if it determined not to exempt itself from the self-funding requirements. Senator Patrick explained that in a self-funded model the reserve would have to be placed in a trust. Ms. Stayner responded that the requirements of Chapter 40, Title 41, Idaho Code, was to have an irrevocable trust. She explained that a general self-funded employer working outside the registration requirements of the Dept. of Insurance would use a general asset account.

Co-chair Lakey invited Director Cameron, from the Dept. of Insurance (DOI), to respond to the committee's questions with respect to the irrevocable trust account. Director Cameron reminded the committee that it was the Dept. of Insurance's opinion that Chapter 40, Title 41, Idaho Code, consisted of best practices that should be followed. He explained that the trust requirement was due to Chapter 40 and that the DOI would have significant concerns and/or reservations about exempting the State or any government entity from this chapter. He added that the DOI was preparing a document for the co-chairs and committee that would indicate the purpose for each of the provisions in Chapter 40, their importance, and why they are best practices. Director Cameron explained that some of the provisions were Employee Retirement Income Security Act (ERISA) provisions that the DOI believed were best practices for added scrutiny and protection to the taxpayers and their tax dollars.

Co-chair Wood stated that when Ada County, which was exempt from Chapter 40, had presented to the committee, it recognized that Chapter 40 provided many best practices. He suggested that the State, if it chose to exempt itself from Chapter 40, could set up an interest-bearing, reserve account, instead of an irrevocable trust, with potentially the same amount of funds; the reserve account could function in the same manner as an irrevocable trust and the State could continue best practices. Director Cameron stated that he had not meant to suggest that the State intended to distance itself from best practices, but suggested that many of the provisions found in Chapter 40 were best practices and the idea of exempting the State from this chapter caused him concern. He explained that the purpose of the irrevocable trust wasn't just the necessary amount of funds, but the manner in which the funds were held; the best practice of setting up an irrevocable trust was to protect the funds so the funding could not be manipulated or used for other purposes.

Senator Johnson referred to slide 21 and asked if the estimated savings of $13 million for healthcare costs would cause a reduction to revenues to the State. Ms. Stayner responded that a small portion of savings was due to the State's premium tax and a larger portion of the savings was attributed to the ACA fees.

Co-chair Lakey asked, if the State were to convert to a self-funding model, how long it should keep the model before it determined whether it was beneficial. Ms. Stayner responded that the State, if it chose to convert to a self-funding model, should proceed with the model as a well thought-out strategy; if the model did not work, it should pursue a different model. She commented that the

State may experience some bad claim years, regardless of what model it chose to pursue, and there could be many factors for those increases. She reminded the committee that the State could keep the same claims administrator and potentially change the cost of the reinsurance to mitigate liability and expense if it chose to self-fund.

Ms. Stayner proceeded to slides 22-23 and summarized the features. She stated that, if the State chose to self-fund, it would open itself up to increased legal and fiduciary responsibility, but that could also be a positive feature. She reminded the committee that it could transfer the fiduciary responsibility as much as it chose to, and it could also make plan determinations with respect to features to include or exclude for the State of Idaho's employee health plans.

Senator Nye asked, if the State chose to self-fund, would it feel the need to spend more funds for additional staff to administer the plan. Ms. Stayner responded in the negative. She explained that if the State chose to self-fund, a carrier would continue to perform the same work, but the funding mechanism would change from a hybrid model to a self-funding model.

Representative Anderson asked if, conceptually, there would be a difference to BCI as the State's carrier if it chose to self-fund. Mr. Jeppesen explained that BCI would still process claims, but the fiduciary responsibilities would shift to the State and the State would have to determine a way to cover those additional responsibilities. Milliman estimated that it would cost $2.7 million over three years to cover the additional responsibilities. Representative Anderson asked, if BCI's fiduciary responsibilities were to shift to the State of Idaho, would BCI reduce its cost to the State as its potential TPA. Mr. Jeppesen responded that BCI would prefer to review any cost changes in detail with the State, but the shift in accountability would result in additional costs to the State, particularly if the State was under Chapter 40 requirements.

Next Steps

Mr. White explained that Mercer's understanding of the committee's next step was to prepare a recommendation to present to the Legislature in January. Assuming that the recommendation was approved by the Legislature, and signed by the Governor, then the State would need to proceed to marketing implementation. He explained that there were different elements of the strategy that would require different work streams. While this meeting concluded Mercer's contract with the State, it was excited and hopeful for a potential opportunity to partner with the State around implementation of the program. Mr. White expressed his desire to respond to any questions the committee might have to ensure that the committee had the information needed to proceed to its next steps.

Co-chair Lakey asked Ms. Lockett to update the committee regarding Milliman's most recent actuarial report. Ms. Lockett explained to the committee that they had received an updated FY2019 Insurance Projection Report, dated November 6, 2017. She reminded the committee that the cost of insurance was different than the amount appropriated. The most recent projection had an appropriation for FY2019 of $8,740 per active employee. This was a decrease from $11,100 that the State had estimated as of this summer, which was the amount budgeted. The basis for the decrease was generally due to lower than expected dental and medical claims. The reason that the State could still pay insurance at the cost of $13,514 per employee was due to the use of reserve funding. The estimated balance for the reserve at the end of FY2018 was $95 million, which was why the State could keep the appropriation low and still fully fund the true cost of the insurance. Ms. Lockett explained that the projection for FY2020 showed a significant increase to $13,000 per employee.

Senator Johnson referred to the September 21, 2017 meeting minutes and his recorded request for the actuarial values for the benchmarks from Mercer's presentation. Mr. White responded that Mercer would provide the actuarial values for the State of Idaho's plans versus the actuarial values for the benchmark plans as a follow-up.

Co-chair Lakey inquired about the appropriate level of reserves based on the State's employee population. Mr. White responded that, generally speaking, a plan sponsor would, at least on an annual basis, have a recommended "incurred but not reported" reserve (IBNR) - an actuarially developed figure based on an examination of lag tables. He explained that the IBNR figure was meant to cover the liability in the event of plan termination. A less common practice was for some self-funded plan sponsors to maintain an additional reserve for claim fluctuation. Mr. White explained that, from a size of liability, the IBNR for a medical plan probably averaged between one to two months of claims data. Co-chair Lakey inquired what the average monthly paid claims were for the State of Idaho. Ms. Pike responded that they averaged about $15 million each month.

Representative Anderson inquired whether there were plan termination costs if the State chose to convert to a self-funded model. Mr. Jeppesen referred to the Milliman document and read aloud, 'upon termination of the current plan under the agreement, the claims incurred prior to the termination date and paid during the runout period, which is six months, will be subtracted from the reserve for incurred but unpaid claims and any applicable contingency reserve. At the end of that period, the State and BCI would negotiate a settlement for any additional liabilities not yet paid.'

Co-chair Lakey called upon Director Cameron to provide additional commentary to the committee. Director Cameron proceeded to address some areas of concern. He reiterated his concern regarding the committee's consideration of exempting the State from Chapter 40, Title 41, Idaho Code. He opined that if Chapter 40 was an appropriate standard for cities and schools, perhaps it was also an appropriate standard for the State as well. He reminded the committee of the public's distaste for the government exempting itself from any statutes. It was the DOI's belief that Chapter 40 provided best practices to protect citizens, public employees, and taxpayers.

Director Cameron stated that, with respect to potential cost-savings, the decision to self-fund was a decision based on how much liability the State wished to take on. He said that, while it might make financial sense, the potential risk that the State and taxpayers would take on may not be worth the savings the State could achieve. He suggested that the majority of the potential savings would derive from the HIT Tax and that Congress may make changes in the future that would address this tax.

Director Cameron opined that the hybrid model afforded the State the same level of flexibility as a self-funded model.

With respect to some of the comments regarding the amount held in the State's reserve, Director Cameron conceded that the State's claim history was stable, but there was still a risk for a potentially high-claims year that would cause the department to ask for an additional appropriation from the Legislature. He opined that it was beneficial to retain a reserve amount of 110%. He stated that, while reinsurance could be purchased, there would be some issues with doing so as well. Director Cameron suggested that, if the State chose to proceed with an RFP process, it should allow the vendors to quote the costs for both a hybrid model and a self-funded model. He stated his wish for the committee to adequately analyze the potential financial risk and additional costs to convert to a self-funding model. He opined that, even with the utilization of a TPA, the Dept. of Administration would need additional staff to handle the changes and additional responsibilities. Director Cameron also encouraged the committee to use incentives, rather than penalizations (e.g., surcharges), to encourage employees to model healthy behaviors.

Senator Patrick inquired about the Dept. of Insurance's method of funding. Director Cameron explained that the Dept. of Insurance operated solely on fees paid by carriers and agents doing business in the State of Idaho.

The committee adjourned for a break at 3:29 p.m.

The committee reconvened at 3:41 p.m.

Co-chair Lakey stated the committee's request to have the full committee present to discuss what actions to take with respect to the current hybrid model, self-funding, next steps, etc. He

commented that Director Cameron would have the Dept. of Insurance's summary information to the committee within the next couple of weeks.

The committee discussed possible meeting dates. After some discussion, the committee members selected December 1 as the next meeting date.

Co-chair Lakey thanked Mercer for their efforts and invited them to attend the following meeting.

The committee adjourned at 3:46 p.m.