MINUTES
(Subject to approval by the Committee)
State Employee Group Insurance & Benefits Committee
Wednesday, August 03, 2016
9:00 A.M.
EW42
Boise, Idaho

Co-chair Senator Lakey called the meeting to order at 9:04 a.m.; a silent roll call was taken. Committee members in attendance: Co-chair Senator Todd Lakey and Co-chair Representative Fred Wood; Senators Jim Patrick and Dan Schmidt; Representatives Robert Anderst, Jason Monks, and Hy Kloc. Senator Johnson arrived after the lunch break. Absent and excused: Senator Robert Nonini and Representative Neil Anderson. Legislative Services Office staff present were: Kristin Ford, Robyn Lockett, and Jennifer Kish.

Other attendees: Director Bob Geddes, Jennifer Pike, Cindy Dickenson, Keith Reynolds, Karen Thiel - Dept. of Administration; Doug Toschi - Propel Consultants; Director Dick Armstrong - Dept. of Health and Welfare; Michael Pearson, Gina Hodge - Idaho Dept. of Fish and Game; Don Drum - PERSI; Gideon Tolman, Jani Revier - Div. of Financial Management; Jody Zauha, Susan Buxton - Div. of Human Resources; Audrey Musgrave - State Controller's Office; Tim Olson - Pacific Source; Jason Kreizenbeck, Carrie Foster - Lobby Idaho; Rep. Sue Chew - Idaho State Legislature; Colby Cameron - Sullivan & Reberger; Norm Varin - Pacific Source Health Plan.

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

Co-chair Lakey invited the members to introduce themselves and then briefly outlined the goals of the committee as stated in HCR 61 (2016). He expressed the intent of the committee to mostly hear from experts on the topic but will offer the opportunity for other legislators and the public to provide comments/opinions. The Co-chair also pointed out that the committee has already established its meeting dates for the next few months.

Co-chair Wood expressed the desire to get as many ideas presented/collected as possible so that the committee could comfortably and confidently present its recommendations to the legislature.

Current Group Insurance Plan Structure

Co-chair Lakey then called upon Director Bob Geddes, Department of Administration (DOA), for his comments to the committee. Director Geddes explained that the Office of Group Insurance (OGI) was housed within the DOA. He reported that over the years as a state senator and even now as the Director of the DOA he was not a member of the state employee insurance program. The Director touted that his expertise and knowledge of the state employee group insurance was in his staff: Jennifer Pike - Office of Group Insurance Administrator; Cindy Dickenson - Benefits Manager; Keith Reynolds - Deputy Director and CFO; Doug Toschi - Propel (private consultant).

He reported that the department has been under contract with Blue Cross of Idaho (BCI) since 2004; on average the contract was rebid every five years, last bid being in 2012. The Director elaborated that, while 16 years may seem a long time with the same company, such company was the only bidder able to meet the requirements established by the department. He further detailed that such contract was renegotiated every year with Blue Cross to re-evaluate compliance with federal and state laws but also to be as competitive as possible for employee needs and benefits offered. The goals of OGI, as stated by Director Geddes, were to: follow the policies of the Legislature, be in compliance with federal and state insurance laws, rules and regulations, be as competitive as possible both in benefits and cost, be as accurate as possible in cost projections, and provide the

best benefits and customer service possible to our customers/employees. Having worked in both the private and public sectors, Director Geddes emphasized how important benefits were to employees in making decisions about where to be or remain employed. He felt that it was an important element in attracting and keeping qualified and competent employees.

Co-chair Lakey asked the Director to identify who placed bids during the last request for proposals. Director Geddes reported that there were three companies that submitted bids; two of those companies were deemed not qualified to accept the bid and provide service and so Blue Cross was awarded the contract. Rep. Anderst inquired whether the qualifications he spoke of were self-imposed or federally-imposed. Director Geddes responded that he could not answer the question accurately as he was not employed in his position at the time it was awarded.

Co-chair Lakey then requested Jennifer Pike to proceed with her presentation. Before beginning, Ms. Pike responded to Rep. Anderst's question regarding the qualifications; she explained that such qualifications were essentially self-imposed due to the fact that one provider only offered a self-funded model, which was not our desire at the time, and the second did not have the infrastructure to support a group of our size. Blue Cross, she explained, was able to meet both of those requirements. Ms. Pike provided an overview of the Office of Group Insurance and its services to state employees, retirees, and dependents of each. Highlights and additional facts for Ms. Pike's presentation included:

- There are three types of plans offered in the medical coverage: traditional, preferred provider (PPO), and high-deductible; each of which included a vision and an employee assistance program (EAP) benefit. Ms. Pike explained that the EAP provided short-term, in-person or online counseling for enrollees and their dependents for five visits per year with no copay.
- For slide 6, it was reported that the traditional plan was most popular with rural communities of Idaho that had limited networks; the PPO plan was the most popular plan overall; and the high deductible was used more often as a secondary plan for prescription drugs.
- For slide 9, it was reported that as of June 30, of the approximately 300 PT state employees, only 50% were enrolled in the state plan; she elaborated that there was no data to study as to why participation was not greater. She also added that the rise in cost was allowable as the Affordable Care Act (ACA) did not require coverage to be "affordable" to those working less than 30 hours.
- Employer pays premium for eligible employee's basic life coverage which includes accidental death or dismemberment and short- or long-term disability. The most often used short-term reason was maternity and the most often used long-term was muscular/skeletal. An employee with an open claim may continue enrollment for up to 30 months following the date of disability.
- Voluntary program: an employee has the option to purchase additional voluntary term-life coverage for up to 3x the employee's salary.
- Voluntary program: Flexible Spending Account for health care or day care.
- Retiree Options: premiums are paid entirely by retiree; dental was additional.
- In Fiscal Year (FY) 12 the state applied for "grandfathered" status under the ACA and has maintained that status. The state accepted certain limitations on cost-sharing that can be shifted to employees, but in exchange the State was exempted from having to implement all of the provisions of the ACA.
- Mandatory changes have had a significant financial impact on the state plan.
- State has unique funding mechanism: once Blue Cross has paid all claims for the month and if they have excess funds that were paid to them - they return it to the state. If after claims are paid there is an outstanding balance then the state pays the deficit. Blue Cross accepts the administrative fee as their compensation for administering the plan.
- When looking at future year total plan cost projections, they consider the expected trend for healthcare costs (both medical trend and prescription drug trend) and the review of utilization of benefits by plan members. The state's plan is trending very much like other large groups in Idaho, in the Northwest, and across the nation.
- The 11% increase from FY17 to FY18 can be attributed to an increase in ACA fees.

- The congressional omnibus budget included a one year moratorium on the health insurer fee. The health insurer fee is based on the cost of the plan and is the largest (80%) accessed ACA fee. For the state, the moratorium on the health insurer fee has offset costs for the total plan year, but without changes to the ACA the health insurer fee is scheduled to return after the one year moratorium; it's been taken into consideration in FY18. The omnibus budget included a two-year delay in the Cadillac Tax.
- The contingency reserve is a commitment to the carrier that in the event that claims and expenses exceed 100% of annualized premiums, the carrier will be compensated. As a result the carrier does not assess a risk-charge to the plan. Any balance not paid to the carrier in a given year can be applied to the next year's financial reserve commitment.
- The reserves can be used (and even depleted); in FY16 the Legislature approved a General Fund transfer of just over $13,000,000 for the state to meet its obligation going into the next year.
- In FY12, the reserve obligation to the Carrier was reduced from 10% to 5% to free up funds, but took on an additional risk-charge of $700,000 for those years; the state used those reserves to address premium increases rather than pass it along to employees. At the end of FY15, the state increased the contingency reserve to 10% again and avoided any risk-charges in the prior plan year.
- Projected medical costs and dental projected costs for FY18 = $353 million

Co-chair Wood asked Ms. Pike if the costs in FY15, FY16 and the projected costs are net costs to the taxpayer (actual taxpayer dollars the State of Idaho pays for health plan). She answered no - it is the total plan cost including everyone's contributions. He posed a follow-up question of what the administrative fee is in terms of a percent basis. Ms. Pike responded that the administrative fee for the current plan year is $10 million; it's a percentage of the annualized premiums that the state is paying to the plan which equates to about 2.8% of the plan cost.

Senator Schmidt asked if keeping the contingency reserves cost was included in the plan cost. Ms. Pike responded that it can be; any reserves funds are carried over from year to year, but there is a factor for increasing assets if there is a need to build up the reserve.

Co-chair Lakey inquired if the State was fully liable for claims exceeding 110% of the total liability. She answered that the financial responsibility would be on Blue Cross, but it's likely they would try to recoup those costs by raising rates in the following years; this has not happened yet. He asked Ms. Pike if she could supply numbers for how far into the reserves the state has gone within the last few years. She responded yes and that she would gather the information for the committee. Co-chair Wood asked Ms. Pike if she could supply a breakdown of how much pharmacy has contributed to the increase of cost of healthcare to the state plan over the last few years. She responded that the medical trend has been about 8% and the prescription trend 13%. Co-chair Wood followed up with the question of whether we would be considered a cadillac plan. Ms. Pike responded that as we are currently constructed we do not qualify as a cadillac plan.

Senator Schmidt asked Ms. Pike if she could describe where the ACA fees go, to which Ms. Pike responded that she was not sure where the fees went once they were supplied to the Federal Government. He also inquired if the state group insurance plan pays a premium tax to the State of Idaho to which she responded yes, and that she could provide that number to the committee. Senator Schmidt asked what the differences are between the state's plan and a self-insurer plan. She explained that the funding model is very similar; to be a true self-insurer plan we'd be required to have a higher contingency reserve as well as a board to make claim decisions and plan designs. We could still contract with a carrier to do the claims administration, but ultimately the liability would be on the state instead of with the carrier. Ms. Pike also clarified that if the plan was truly self-funded, it would not have a stop-loss and the state would have to purchase insurance specifically for a stop-loss.

Representative Kloc asked how many state employees (full-time and part-time) the state has. She responded that the state has about 20,000 full-time employees and 300 part-time employees; currently there are about 18,600 full-time and 160 part-time employees enrolled in the state's plan.

Co-chair Lakey asked if basic life insurance and disability are accounted for in the cost projections. She responded no and clarified that basic life insurance is a percentage of payroll (0.675% for any individual) and is done through the salary process. She further explained that each agency pays the premium to the Office of Group Insurance and the Office of Group Insurance administers the program; it is a self-funded program and they have a TPA that helps pay the benefits. Co-chair Lakey asked Ms. Pike if she could calculate how much it would cost for an individual to purchase medical, dental, and any other benefits outside of the state plan to which she responded in the affirmative. Co-chair Wood asked if an expert or a staff member could speak to the committee on how to compare costs between the state plan and other plans. Ms. Pike offered that Mr. Doug Toschi may be able to address this request if he has ample time when presenting.

Representative Anderst inquired how long the state has offered [Employee Assistance Plan] benefits and what the utilization rate trend is. Ms. Pike answered that the benefit has been offered for about 10 years, but she would need to gather the utilization rate data and could provide the information to the committee at a later date. Senator Schmidt asked if the DOA had any information on whether the Thrive Idaho Program (which has since been dropped) was beneficial or not. She responded that they are still waiting on the reports for the two years the plan was offered to compare them side by side.

Representative Monks asked if the committee could be provided a breakdown of which employee contributions (co-pays, deductibles, etc.) are increasing. Ms. Pike responded in the affirmative and further explained that the state's plan structure has not changed, but more people have been added to the state's plan. He followed up with another question of whether there has been increased utilization. She responded in the affirmative - particularly in the pharmacy section.

Co-chair Lakey asked if the funds in a flexible spending account (FSA) would be lost if they weren't used. Ms. Pike responded that the day-care FSA does not allow for rollovers, but a medical FSA allows for a rollover of $500 from year to year. Co-chair Lakey thanked Ms. Pike for her presentation.

The committee proceeded to take a short recess of 15 minutes.

The ACA: Exploring the Grandfathered Status of Our Current Plan

Mr. Doug Toschi introduced himself and explained his background as a consultant for Propel Consultants. He began his presentation by defining "grandfathered plan" as any plan that was in existence in March 23, 2010 (effective date of the ACA) that has not made significant prohibitive changes. If a plan is grandfathered, it is exempt from certain healthcare reform requirements. The DOA created some guidelines to maintain grandfathered status; there are some changes that can be made to the plan without losing grandfathered status. He proceeded to list the prohibitive changes that would cause the state to lose its grandfathered status:

- Significantly cutting or significantly reducing benefits;
- Reducing coinsurance payment;
- Changing co-payments (some minor exceptions - explanation on slide);
- Significantly raising deductibles (some exceptions - explanation on slide);
- Significantly reducing employer contributions; and
- Adding or tightening an annual limit on what the insurer pays.

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

- An example of what could cause loss of grandfathered status by adding or tightening an annual limit on what an insurer pays could be reducing a preventative care benefit payment from $500 to $300.
- The date for loss of a grandfathered status is the date on which the change in plan becomes effective.
- The deductible for an individual could be increased a certain percentage, for example, from $250 up to $325, for example, and the state would maintain its grandfathered status (according to the statistics in Milliman's Report); this would save the state money. The maximum out-of-pocket cost for an individual using an in-network provider, for example, could be increased from $3,250 to $4,270 as well.

- If the State was to forgo grandfathered status there would need to be additional immunizations covered (i.e. HPV virus, etc.) and additional coverages (i.e. well child vision and developmental screenings, colonoscopy, etc.)
- The estimated cost to forgo grandfathered status would be between 0.25% - 0.35%; some clinical trials may be required to be covered and there is not a way to define what that cost would be.

Co-chair Lakey asked Mr. Toschi who is it that defines the medical inflation. Mr. Toschi replied that he uses a report that was provided to the Legislature in February from Milliman Associates regarding potential plan changes, self-funding, etc. Milliman has well-known healthcare cost guidelines that they developed based on national data that they do an analysis on and publish every year. The numbers on medical inflation used in this presentation are based on Milliman's healthcare cost factors; there are other ways to examine cost factors though. He opined that the frequency of large (million dollar) claims increasing plus the cost of pharmaceutical drugs are driving the cost of the healthcare plan. Co-chair Lakey asked if the medical inflation rate could be different in our state versus another state. Ms. Toschi replied that it could fluctuate since Milliman uses national data; the sample size of more than the state employee workforce would need to be used (i.e. total book of business) to justify it statistically.

Co-chair Wood asked if the state would lose its grandfathered status if it was to take the position that the rate of reimbursement to all private carriers for anyone who becomes eligible for medicare would be medicare rates. Mr. Toschi replied that the grandfathered status would not be lost, but it does not preclude lawsuits from being brought against patients. He further clarified that the state is not reimbursing at retails rates right now.

Co-chair Lakey inquired if Mr. Toschi or the DOA would be able to supply the medical inflation rate for this year, last year, the year before and future projection rates. Mr. Toschi replied they could, but reminded the committee that a trend factor is used when one is projecting rates which consists of 2 things: expected inflation rate for the next year + increase of utilization benefits (which typically happens each year). He explained that it is prospective in nature when it's done and that it does not always end up the way it was projected when examined retrospectively.

Representative Anderst asked if premiums could be increased within the statutory allowances for one category (i.e. family) but not another (i.e. individual) and the state still maintain its grandfathered status. Mr. Toschi responded yes and that it is done also in the private sector. Senator Schmidt asked if the ACA fees would change if the State was to forgo its grandfathered status. Mr. Toschi responded in the negative. Senator Schmidt asked for clarification on where the ACA fees go. He explained that the reinsurance fees go to fund reimbursements in the exchange for high-cost claims; the reinsurance premiums that were collected were not reimbursed at the level they expected. The PCORI (patient-centered outcomes research institute) fee is a comparative-effectiveness research tax that goes to Health and Human Services to do analytics on medical conditions to produce recommendations in regard to treatments, etc. The premium tax goes to fund the ACA in general.

Co-chair Wood asked if the grandfathered status would be affected if they were to increase coverage by adding additional coverage; he opined that some items listed on slides 21 and 22 should be covered. Mr. Toschi replied that it would not create an issue. Co-chair Wood agreed with Mr. Toschi's recommendation to discuss the method of self-funding at more length in the future. Mr. Kloc asked if it was Mr. Toschi's opinion that it would be worth the State giving up the grandfathered status to include those benefits. Mr. Toschi answered that some or all of those additional coverages listed on the slides could be added to the plan without the State giving up its grandfathered status.

Mr. Monks asked if there was enough data to support that there would be savings if the State was to provide additional coverages. Mr. Toschi replied that in all likelihood there would be money saved in the long-term, but it would not be an immediate term. Mr. Monks asked if there is more utilization of coverages if they are part of the preventive care. Mr. Toschi replied that some plans

cover additional preventive care because they believe it is important and with the hope that it will be done, but the utilization trend comparisons are difficult to quantify.

Senator Schmidt asked if Mr. Toschi was aware of a state to state comparison of how much cost-shifting occurs - whether there is a correlation between private insurance cost increasing if medicare/medicaid reimbursement payments are low or uninsured. Mr. Toschi explained that in the case of group insurance it actually reduces the cost; there are few employees at the age of 65 who are covered by group insurance. If there is an active employee at 65 or older and he has group insurance, he said, medicare then becomes a secondary payer.

Co-chair Lakey asked if there was a sunset in legislation in regards to the grandfathered provision. He responded that there was no sunset clause at this point.

Mr. Toschi provided general comments about the plan and opined that the group insurance plan is competitive within the area, but suggested the committee consider raising the maximum on dental coverage. Co-chair Lakey thanked Mr. Toschi for his presentation and time.

The committee proceeded to take an hour lunch break. Senator Johnson joined the committee after the lunch break.

History and Background of Idaho's State Employee Insurance Plan Structure (1990-2006)

Co-chair Lakey called upon Director Dick Armstrong, Department of Health and Welfare, to present next. Director Armstrong explained that in 2006 he retired from Blue Cross as Senior Vice President of Sales and Marketing, and was the party responsible for either managing the state contract or trying to obtain the state contract. For 40 years, he said, the state's rates were based on the claims experience of the state's employees. Prior to 2004, there were some processes that were somewhat different. For example, he explained, the administrative fee was based on a percentage of the claims' costs and the reserves were held by the carrier. In 2003, when the state contract came up for bid, there was a movement in the country called self-insurance which was important to certain employers for the following reasons:

- Reduce administrative cost;
- Avoid premium tax;
- Cost management; and
- Flexibility and benefits.

The question that Blue Cross recognized, the Director stated, was how to emulate as much of the self-insurer principles as possible without going through an ERISA-preemption for self-insurance. There was a major pressing issue of how to compare the contracts that a carrier has with healthcare providers and its value. The state proceeded to contract with Milliman to do a repricing of the prior year claims which would provide a clear understanding of the value of those provider agreements; network pricing showed deeper discounts and a net lower cost to the State of Idaho by awarding the contract to Blue Cross.

The second issue to address in an effort to make this plan more like a self-insurer plan, Director Armstrong explained, was the administrative fee; the decision was made to present a fixed cost per employee per month. The value of this, he explained, was that it had no automatic inflation.

The third concern was reserve management. He described 3 types of reserves that are typically part of this kind of plan:

- Incurred but not reported claim reserve;
- Dedicated (contingency) reserve; and
- Surplus reserve.

The reality of utilization for medicaid and for state employees is that 80% of costs are driven by the physician's pen. Director Armstrong's suggestion for the state's health plan was to move away from "fee-for-service" payment for healthcare.

He summarized that the management of the state plan has been solid, the value statement set in 2004 is still present, the administrative fee is still quite low, and the value of the plan is extremely important to the directors with large agencies. He stated that total compensation is important to employees and a useful strategy to attract and retain employees. Director Armstrong made a point to emphasize that state employees still have a significant out-of-pocket costs expense.

Senator Schmidt asked Director Armstrong if they were not contributing more to the rise of healthcare inflation as part of this system. The Director responded that if the state reduced the benefits or placed more of the burden on the employee, it would not change the outcome other than the employee would potentially struggle financially. If the payroll deduction cost was increased, he said, it may result in family members not having medical insurance, potentially ending up with debt, and the cost passed to everyone or addressed through the catastrophic fund. He opined that if the health system was receiving a fixed reimbursement for every employee that was attributed to their health system, there would be a different discussion to the diagnostic process and whether less-expensive means could have been utilized to solve that diagnostic question.

Co-chair Wood asked if Director Armstrong would comment on being able to maintain the grandfathered status as well as the current benefit structure, and still look to other platforms of financing or reimbursement to the healthcare delivery system such as managed care, accountable care organization, etc. He responded that in his own personal studies, he has yet to see anything in the ACA that would cause the state to lose its grandfathered status simply because we changed the network, carrier, or insurance company; they are by themselves not triggers to leave the grandfathered status, but combinations could be a challenge. He explained that if they just isolated this, such as changing the PPO plan to have multiple networks under the PPO benefit design for example, it would most likely not be a trigger to lose the grandfathered status unless benefits were reduced.

Co-chair Lakey asked the Director what limitations he felt existed or still presently exist to doing self-funding. The concept of self-funding, Director Armstrong explained, implies that one is financing the program as one goes. The State Constitution requires a balanced budget, and the feeling was that at the end of a fiscal year the state could have a series of transactions that would place the expense above the appropriation and therefore deemed to be deficit-spending carrying costs. However, Director Armstrong explained, this could be avoided by buying reinsurance that would state that in no case can the cost exceed the current budget, or the state could use reserve funds to accomplish the same goal. To avoid addressing this risk, this path was not chosen. He also suggested exploring all layers of cost associated with this potential path. The state could possibly reduce the administrative fee by half a percent, he said, but if the network pricing increases it may not make a positive difference. He explained that the analysis that was done by the Dept. of Administration and Office of Group Insurance in the past did not see a savings by pursuing this process.

Senator Schmidt asked Director Armstrong if the health insurance tax that is in the ACA was considered in 2004. He emphatically responded no, that at time there was no thought of the ACA ever occurring at the federal level.

Senator Lakey asked for more clarification regarding the comment made about changing how the state pays for healthcare and the incentives - was it meant systemically or specific changes that would be implemented in the state benefit package. Director Armstrong replied that he meant systemically - global changes on how the State pays for healthcare. He opined that success would be the ability to moderate the rate of increase of costs and also improve the quality of healthcare delivered. Senator Patrick asked if in the Director's vision of managed care would there be patient participation in the pay. Director Armstrong clarified that the benefit design would not need to change under the envisioned model.

Co-chair Wood asked Director Armstrong to briefly explain the ERISA (employee retirement income security act) preemption. Director Armstrong explained that what ERISA said when the law was

implemented was that if an employer deemed their health plan to be self-insured and they could get an exemption from complying with state law and would then comply with a set of federal requirements. There was a significant advantage in some states for employers to implement a self-insured plan to evade certain state mandates he said. However, the Director stated, this plan was also selected for many large employers who had employees in various states and struggled with different mandates from various states.

Current Group Insurance Plan Costs and How It Is Funded

Co-chair Lakey then called upon Ms. Robyn Lockett, Principal Budget and Policy Analyst, Legislative Services Office (LSO), to begin her presentation to the committee. Ms. Lockett explained that each year the state contracts with the actuary group Milliman. The analysis is conducted to assess the financial health of the insurance plan as well as determine how much the plan will cost the state. The Legislature makes policy decisions about the insurance plan structure each year and then directs Dept. of Administration (DOA) to implement those policies. In recent years, the recommendations have been derived from the Governor's recommendation, further refined by the CEC Committee, and ultimately approved by the Legislature. DOA then supplies Milliman with those policy inputs that it uses to provide the state a report that includes cost-projections about the plan as it's designed. The policy input is also influenced by Propel Consulting who works directly with the Office of Group Insurance. In most years, the actual costs of the incurred claims on the state's plan end up being a different number than what is appropriated within each agency's budget which is generally attributable to timing and to how much information is known at the time the budgets are set. She also stated that there is both a method of how the state has opted to pay for insurance and the actual cost of that insurance.

Ms. Lockett began her presentation which included details of the current group insurance plan and an explanation on how it is funded by the state. Highlights and additional facts for Ms. Lockett's presentation included:

- The vast majority of the costs are the claims incurred by the employees and their dependents enrolled in the state plan ($237 million of the $264 million cost).
- The Insurance Premium Tax is assessed on 1.5% on insurance premium policies in Idaho. In FY15, the amount distributed was $81 million of which $61 million went to the General Fund.
- Funds are allocated for all state employees regardless if they opt-in or out of the insurance plan. If employees elect not to enroll in the state plan, their funding allocations are still swept from the agency budget and deposited into the Group Insurance Fund. The fund is a continually appropriated fund that pays for the plan. This is not an excess-funding on top of what the state is projected to pay for the plan - rather it's a cost-allocation model. The state does not pay a premium for those employees that opt-out and they are not covered in the plan.
- The manner in which the state finances the plan is up to the state, although the Federal Government does require that they not be overcharged for their portion of the cost in the budget. The appropriation to pay for the cost of the plan includes: general funds, dedicated funds, and federal fund dollars.
- The state, as the employer, pays for about 80% of the total plan cost.
- The reserve fund balance as of June 30th was $35 million, but final number will be available in mid-August. The actuaries estimate that reserves will have been drawn down by about $9 million and will likely begin FY17 with a beginning balance of about $26 million. It's been projected that the reserve funds will increase in the next few fiscal years based upon current plan structure and design.
- State agencies will include $13,460 in their FY18 budgets per FTP (10% increase from the prior year).
- From FY2006 to FY2008, the state used reserve funds to keep the appropriation amount the same as the reserve fund balance had been building up prior to those years.
- From FY2009 to FY2012, the appropriation went down 1.7% - some of the reduction was due to use of reserve funds. The "sweep" methodology was implemented through JFAC during this time and had an ongoing fiscal impact in cost-savings to the state.

- FY11 & FY12 each had 2 months of health insurance premium holidays that were paid with reserve funds rather than paid by the employer. The state also opted to shift some of the cost to the employees in these years while in other times the state opted not to.
- FY2009 to FY2018 shows an effort to contain the appropriated amounts to a certain degree by considering plan designs and using reserve funds. This is illustrated in slide 8 by costs having gone up more quickly than the appropriation.

Ms. Lockett clarified that this presentation included the experience and trends within the State of Idaho. She emphasized that the Legislature has had many discussions about how costs are managed and about the structure of the current plan, particularly in light of the ACA. She reminded the committee that the intent language in HB323 in 2011 only lasted a year; the committee is not necessarily tied to that status through any intent language. Since then, there has been no direction to the DOA on how the Legislature would like to proceed with the grandfathered status, with the exception of the CEC Committee. Ms. Lockett stated that it would be less than $1 million to give up the grandfathered status. Some states have managed their healthcare obligations by looking at the impact of healthcare as a whole in terms of their total state responsibility (i.e. managed care for employees, indigent services, prison population, etc.); our state is a large employer and has a great amount of purchaser power.

Plan design and the ability to shift costs to employees can be different to some degree in the private sector than it would be in the public sector. For example, Ms. Lockett explained, if a private sector employer opts not to cover some benefits, those industries can potentially shift those costs to the state if those costs become absorbed though other healthcare coverages provided by the state. As a purchaser of a plan, she said, the state could better understand the cost drivers, and with enhanced data policymakers may have subsequent options about managing those costs. The DOA is working with our contractor to obtain utilization information/enhanced data to help the Legislature understand where costs are being incurred to either appropriately fund them or address them.

Co-chair Lakey asked Ms. Lockett to clarify if the presentation included costs for life insurance or any other additional benefits. She replied that the entire presentation included only medical, dental, and vision in an effort to achieve a more accurate comparison.

Senator Johnson asked what happened to the funds that were not swept prior to the 'sweep' process being implemented. Ms. Lockett replied that prior to either 2009 or 2010, when the sweep mechanism was not in place, agencies that did not have to pay a premium on some of their employees to the continually appropriated Group Insurance Fund would use those funds for operating expenses, etc. and not for the purpose for which they were intended.

Senator Johnson asked Ms. Lockett to comment about the Wellness Program that was removed. She replied that the cost of the plan was just under $1 million for each of the two years it was in place. For FY17, she explained, the Governor's Recommendation was that wellness program not be renewed and incur the savings per FTP in the appropriation and also incur the savings on the cost of the plan itself; the recommendation to forgo the plan was supported by the Legislature.

Senator Schmidt asked Ms. Lockett why this specific cost-allocation sweep model was put in place. Ms. Lockett responded that this model was intended to keep funds appropriated for insurance in an agency's budget for that purpose. She stated that this model was chosen in keeping with what we know about the reserves and our workforce in 2010; it's something that can certainly be reviewed.

Representative Anderst asked how quickly, in the context of the committee's charge, a survey could be done to ask state employees where they would like 'the next dollar' to be invested. Ms. Lockett replied that the fiscal note allows for an expenditure of $10 thousand; it states that there could also be additional costs incurred to the Division of Human Resources or the DOA, and opined that the committee could consider using funds for outreach.

Co-chair Lakey thanked Ms. Lockett for her presentation and asked if Ms. Pike would briefly explain the handout (see handout) she had provided that included responses for many of the questions the committee members had posed earlier.

Co-chair Lakey asked if the premium tax fee was returned to the General Fund. Ms. Pike responded that her understanding was that the premium tax that is paid to Blue Cross and then paid to the State is deposited into the General Fund. Co-chair Lakey thanked Ms. Pike for her time and efforts in gathering this information.

Co-chair Wood thanked all the presenters and their work in gathering all the information for the committee. He named the 4 components that he felt encompassed the meeting were:

- State's financing mechanism;
- Grandfathering issue;
- Self-funding issue; and
- Issue of cost-drivers/financial liability transfer issues.

Co-chair Wood explained that he would eventually like to see a system in which there is a transfer of all the liability to the healthcare delivery system and allow the healthcare delivery system to internally transform itself. He stated his belief that doing so is the secret to the future of how we control cost in the system, and to potentially consider a hybrid system to address the entire state. Besides self-funding, he said, the committee should consider what further information they would like to request regarding the grandfathered status, the self-funding issue, etc. for the next meeting.

Representative Anderst asked if the DOA was currently in the process of bidding the insurance plan given the last time it was done was in 2012. Ms. Pike responded no - they did not want to get ahead of what changes/requests the committee may consider; it is something the DOA will be doing soon as it is standard for a bid to be done every 5 or 6 years for a group of this size.

Co-chair Wood asked Legislative Services staff to make a presentation about how one would try to compare the benefits and the costs of the current state plan to other plans that can be found on the exchange, or any other ideas that other legislators may present. He recognized that this question had been posed by some legislators in the past and would most likely come up again, and it would be useful for the committee to have a methodology to compare those ideas.

Co-chair Lakey reminded the committee of the future meeting dates - the next one being on September 1, 2016. He thanked all the presenters and the committee members as well for their time and efforts.

The meeting was adjourned at 3:23 p.m.