Attachment #1
Senator Thayn

CEC Health Plan

If we could have stabilized the rising cost of health care, instead of approving a 3% CEC we could have approved a 5% CEC. Stabilizing the cost of the health care plan does not mean reducing benefits or shifting cost to the employees. I believe access can be increased, outcomes improved, and costs reduced.

We have to come to the realization that the structure of the State of Idaho's state employee health plan is what is driving up the costs. The current plan is encouraging over-utilization. The costs will continue to rise unless structural changes are made. What would those changes look like?

One of the state employee health plans that I have been watching is Indiana's plan. It is a voluntary plan that began in 2006 with 4% enrollment. Enrollment has steadily grown until 2014 with 98% enrollment, the latest figures I have.

Indiana calls the plan a CDHP or consumer driven health plan which employees a high deductible health policy with a funded HSA. In 2006, the plan began with a $1,500 deductible for single and $3,000 for family with the state contributing 60% of the deductible to the HSA or $900 for single and $1,800 for family.

This is not all. A wellness plan exists that manages disease and encourages preventative care.

I envision the future Idaho state employee plan being made up of the following elements.

1. A high deductible plan and a PPO for choice
2. Analytics to see which employees are high utilizers so that steps can be made to manage care.
3. Signing up high utilizers of medical care with a DPCMH or direct primary care medical home which is the term being used in New Jersey. The DPCMH approach would basically hire a primary care provider for a monthly fee to manage care, coach, and help establish healthy habits. Director Armstrong said yesterday in JFAC that chronic health conditions account for 75% of all medical costs.
4. For those employees that get preventative care and the high utilizers that follow medical advice under the DPCMH system, they would pay the same premiums as other employees. For those high utilizers that do not follow medical advice, their premiums would go up.
5. Finally, to deal with drug costs and the high cost of medical procedures, I would recommend a 'right to shop' provision. This program works in other states that allow the employee to find out what the payment the insurance company pays for a procedure. For example, a knee replacement may be reimbursed at $25,000. If the employee finds a provider that charges less say $15,000. The employee is paid $5,000 and the program saves $5,000. In Indiana, this is called "Castlight" and Indiana reports a 16.9% decrease in drug and medical costs for those employees that search at least two weeks in advance.

The key is to structurally change the system so that outcomes are better, employees have skin in the game, and costs are controlled. This is a new world. I would like to make a motion that the CEC committee support the governor's increase in health care costs this year and direct the legislature to make structural changes to the system in the coming 12 months.

CECC Meeting

1/19/16