HEALTH WEALTH CAREER

STATE OF IDAHO BENEFIT STRATEGY DEVELOPMENT

MEETING #3: DESIGN

SEPTEMBER 21, 2017

AGENDA

Draft Strategic Roadmap
Benchmarks Review
Financial Impact of Medical Plan Changes for 2019-2020
Self-Funding Overview And Strategy
Self-Funding Requirements for Public Sector Employers in Idaho
Next Steps
Appendix -
• Prioritization of Additional Opportunities
• Guiding Principles
• Self-Funding Definitions

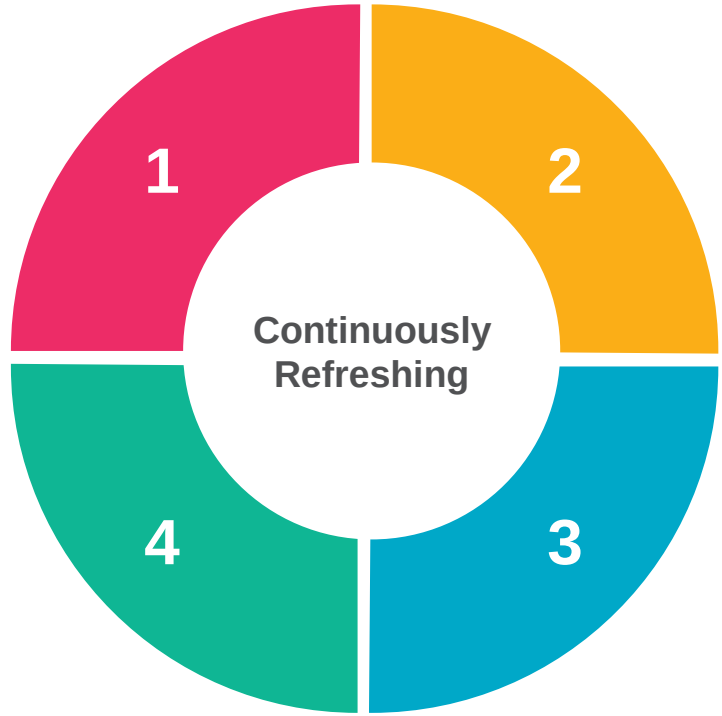
DRAFT STRATEGIC ROADMAP

THE VITALS FOR CHANGE - STATE OF IDAHO
YOUR GO FORWARD STRATEGY

MACRO CONTEXT

Environmental context

- *"Vitals for Change" – a Mercer Point of View*
- *Market trends*



YOUR BASELINE

Understanding current state

- *Interim Committee's input*
- *Office of Group Insurance Input*
- *Benchmarking*

YOUR STRATEGY

Go forward strategy

- *Finalize your plan and take action!*

YOUR OPTIONS

Evaluating approaches

- *Your opportunities and solutions*

A successful strategy delivers your business and financial objectives

THE VITALS FOR CHANGE - STATE OF IDAHO
BALANCING HEALTH AND BENEFITS PRIORITIES

BUSINESS PRIORITIES

- Affordable Benefits for all employees, including their dependents
- Employee Choice/Accountability
- Ensure healthcare/benefits strategy and solutions are relevant to the employee's
- Offer competitive benefits, comparable or better programs
- Promote Well-being – Ongoing cultural change
- Managed Cost/Budget
- Secure "best in class" services and benefits administration solutions?

COST PRIORITIES

- Keep State's health care spend at or below a determined threshold
- Maximize options, but minimize cost pass through to all employees
- Develop and expand upon a Value Based Care model
- Ongoing evaluation of innovations for cost management opportunities

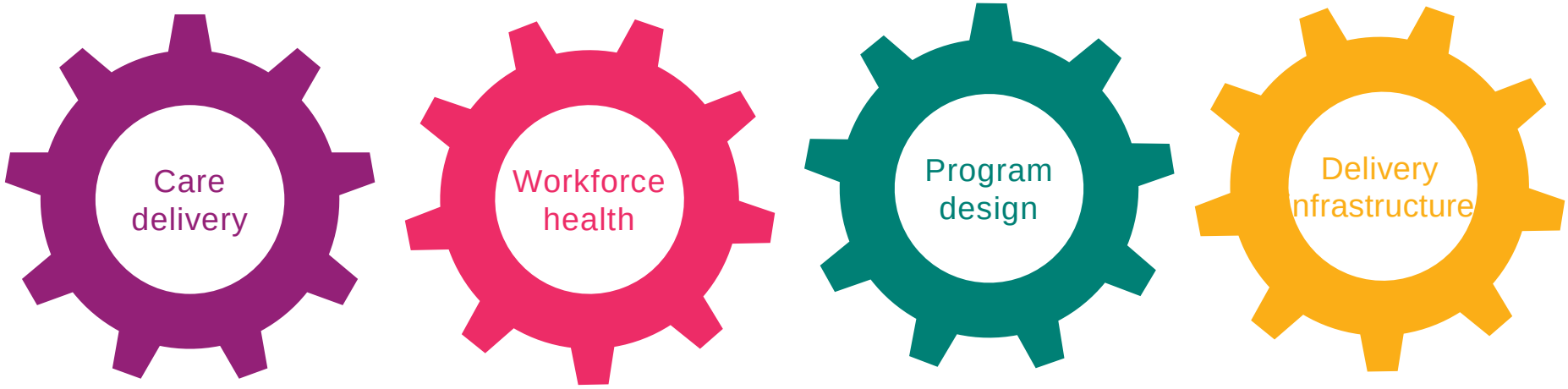
EMPLOYEE PRIORITIES

- Maximize employee benefit choice
- Empower employee benefit accountability
- Offer programs to support employee health improvement
- Access to well-being resources, incentives
- Provide education, resources and tools to better manage their healthcare

THE VITALS FOR CHANGE - STATE OF IDAHO

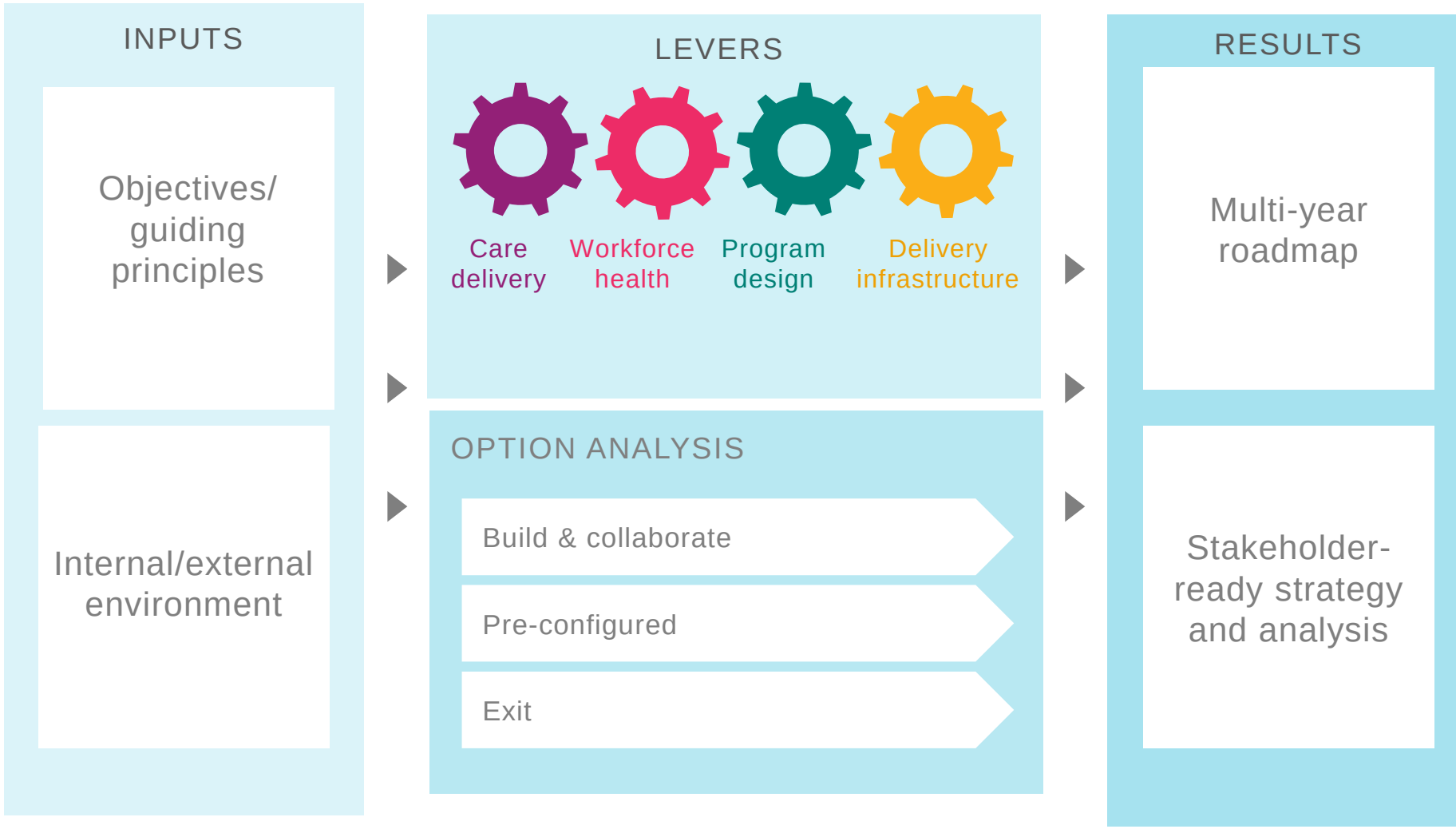
STRATEGIC LEVERS –

THE ELEMENTS OF YOUR STRATEGY



How and where a member accesses care	*How an employer influences behavior and health*	*Who is offered what benefits and how they pay for them*	*How an employer organizes to deliver and finance benefits*
• Value-based care (e.g. ACO, PCMH, other) • New care settings (e.g. telemedicine, onsite/near clinics, retail, Direct Primary Care (DPC) • Carrier network optimization • Direct contracting	• Health status awareness • Education/access to resources • Incentive strategy • Physical health environment • Health management programs • Well-being focus	• Plan design offerings/ values • Contribution strategy • Eligibility • Enrollment/shopping experience • Expanding “core” and “voluntary” • CDH/HSA-Promote consumerism	• Vendor management • Data warehouse • Funding strategy • Insourcing vs. outsourcing • Carve-in vs. carve-out • Risk management (e.g. stop loss) • ACA reporting

THE VITALS FOR CHANGE - STATE OF IDAHO
MERCER'S STRATEGY FIRST-INTEGRATED FRAMEWORK



STATE OF IDAHO MULTI-YEAR STRATEGIC ROADMAP

STRATEGIC LEVER	2018-2019	2019-2020	2020-2021	2021-2022
CARE DELIVERY	• Understand Value Based Care (VBC) solutions available through Blue Cross of Idaho • Conduct exploration of telemedicine solutions in the market • Assess outcomes of current Blue Cross of Idaho care management (CM) programs	• Add VBC steerage for PPO plan • Implement telemedicine • Explore near site clinics at key locations • Review Expert Medical Opinion to supplement medical vendor CM programs • Review Centers of Excellence (COE) options (vendors and direct contracts)	• Launch COE program • Launch near-site/on-site clinics where feasible and appropriate • Launch Expert Medical Opinion	• Implement expanded VBC/COE offerings, including direct contracting if necessary
WORKFORCE HEALTH	• Review point solution program options for weight/diabetes and cancer • Complete the HERO Best Practice Scorecard to identify gaps and develop a well-being strategy leveraging evidence-based approaches	• Launch cancer and diabetes/weight management programs • Review point solution program options for maternity • Launch evidence-based well-being strategy • Introduce a tobacco-use surcharge	• Launch maternity program • Explore transition to outcomes based incentives and specifically targeting top risk areas	• Implement outcomes based incentives
PROGRAM DESIGN	• Begin education campaign for HSA and VBC options to be available 7/1/2019 • Explore transparency/advocacy vendor options • Explore salary-based contribution approaches • Explore variation in HSA funding by salary level	• Launch new medical program structure offering a market-median PPO plan with higher benefits for higher quality providers alongside an HSA option • Conduct voluntary benefits needs assessment • Introduce a spousal surcharge	• Monitor plan values against market, make adjustments as appropriate • Launch voluntary benefits program	• Monitor plan values against market, make adjustments as appropriate
DELIVERY INFRA-STRUCTURE	• Conduct RFP process for medical administration including self-funded proposals and assessment of VBC capabilities • Explore feasibility of carving out pharmacy, including collective purchasing options	• Implement medical and pharmacy vendors based on RFP process • Monitor competitiveness of vendor programs and fees	• Monitor competitiveness of vendor programs and fees	• Monitor competitiveness of vendor programs and fees

BENCHMARKS REVIEW

INTERNAL ENVIRONMENT
PLAN DESIGN BENCHMARKING — PPO

OBSERVATIONS ON OVERALL PLAN ELEMENTS COMPARED TO KEY BENCHMARKS

	State of Idaho	Gov't 500+	State Gov't 500+	National 500+
	PPO	PPO	PPO	PPO
Individual/Family Deductible	$250 / $750 ●	$500 / $1,000	$423 / $900	$600 / $1,500
Individual/Family OOPM	$3,250 / $6,750 ●	$2,500 / $5,000	$2,985 / $5,970	$3,000 / $6,600
Cost-Sharing – Physician Visit (PCP/SPC)	$20 / $20 ●	$25 / $40	$25 / $43	$25 / $40
Cost-Sharing – Hospital Stay (Co-Pay / Coinsurance)	15% ●	$250 / 20%	$250 / 20%	$275 / 20%
Cost-Sharing – Emergency Room (Co-Pay / Coinsurance)	15% ●	$150 / 20%	$100 / 20%	$150 / 20%

● *Favorable compared to benchmark* ● *Unfavorable compared to benchmark*

Source: Mercer's National Survey of Employer-Sponsored Health Plans, 2016

INTERNAL ENVIRONMENT
PLAN DESIGN BENCHMARKING — HSA

OBSERVATIONS ON OVERALL PLAN ELEMENTS COMPARED TO KEY BENCHMARKS

	State of Idaho	Gov't 500+	State Gov't 500+	National 500+
	High Ded.	HSA	HSA	HSA
Individual/Family Deductible	$2,000 / $6,000 ●	$2,000 / $4,200	$1,500 / $3,000	$1,800 / $3,900
Individual/Family OOPM	$5,000 / $10,000 ●	$3,000 / $6,000	$3,400 / $6,300	$3,750 / $7,000
Account Funding	None ●	$600 / $1,000	$723 / $1,300	$500 / $1,000
Cost-Sharing – Physician Visit	30% ●	20%	20%	20%

Note that the current High Deductible plan offered to State Employees is **not** a Qualified High Deductible Plan, so employees are ineligible to make or receive HSA contributions, due to the fact that prescription copays apply before satisfaction of the deductible.

● *Favorable compared to benchmark* ● *Unfavorable compared to benchmark*

Source: Mercer's National Survey of Employer-Sponsored Health Plans, 2016

INTERNAL ENVIRONMENT
EMPLOYEE CONTRIBUTION BENCHMARKING

STATE OF IDAHO CONTRIBUTIONS FOR FULL–TIME FY2017

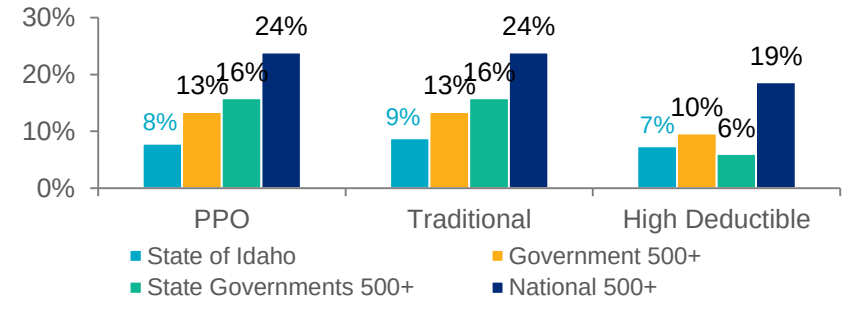
Monthly employee $ contributions:

% employee cost share:

Individual

Individual $

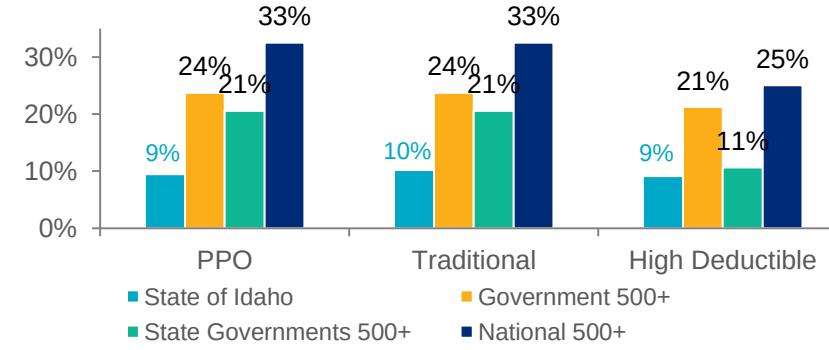
Plan Type	State of Idaho	Government 500+	State Governments 500+	National 500+
PPO	$47 ▼	$83	$126	$132
Traditional	$58 ▼	$83	$126	$132
High Deductible	$38 ▼	$47	$35	$84



Family

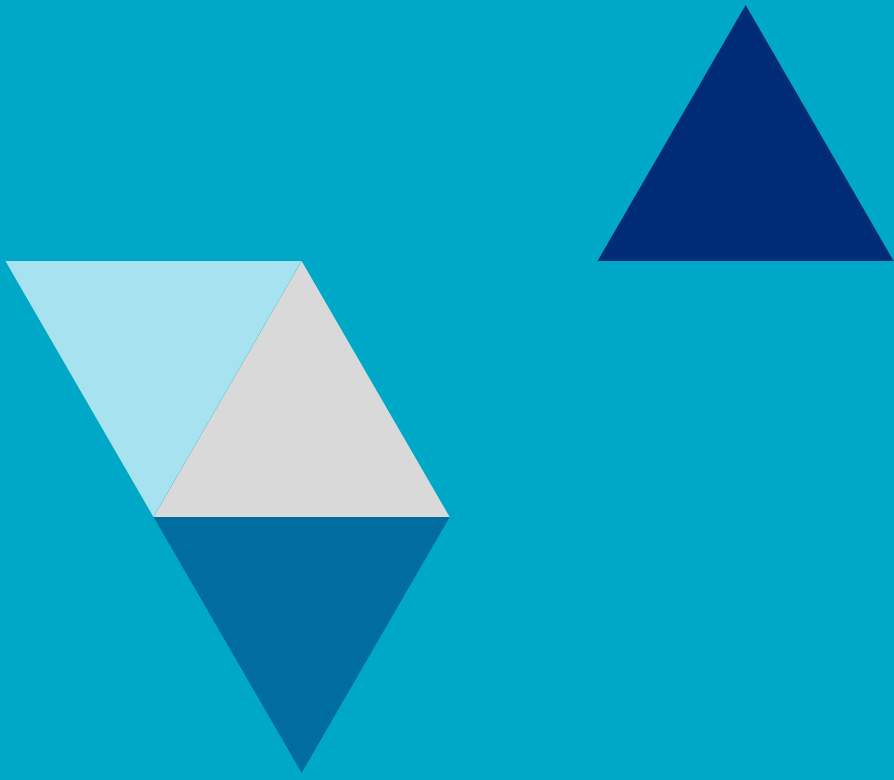
Family $

Plan Type	State of Idaho	Government 500+	State Governments 500+	National 500+
PPO	$171 ▼	$349	$337	$467
Traditional	$202 ▼	$349	$337	$467
High Deductible	$141 ▼	$248	$144	$321



Source: Mercer's National Survey of Employer-Sponsored Health Plans, 2016

FINANCIAL IMPACT OF MEDICAL PLAN CHANGES FOR 2019-2020



POTENTIAL IMPACT OF MEDICAL PLAN DESIGN CHANGES FOR 2019-2020

INTRODUCTION

- Review financial impact of proposed medical plan and employee contribution changes based on prior feedback and strategic discussions
- In this section, we have not explicitly included the potential impact of other strategies under consideration (e.g. telemedicine, value based care, etc.)
  - In the Appendix, we've included commentary on potential cost impact ranges of the various additional strategies included in the strategic roadmap

MEDICAL/RX
PLAN DESIGN AN COST SUMMARY

	CURRENT			PROPOSED	
	PPO	HDHP	Traditional	PPO	HDHP
Insurance carrier	BCI	BCI	BCI	BCI	BCI
Funding status	Self-Funded	Self-Funded	Self-funded	Self-funded	Self-Funded
Deductible (single/family)*	$250/$750	$2,000/$6,000	$350/$1,050	$500/$1,000	$2,000/$4,000
Out of pocket maximum (single/family)	$3,250/$6,750	$5,000/$10,000	$4,300/$8,600	$3,500/$7,000	$3,500/$7,000
HSA account funding from State of Idaho (single/family)	N/A	N/A	N/A	N/A	$500/$1,000
Coinsurance (plan paid)	85%	70%	80%	80%	80%
PCP Office Visit	$20	Ded & Coin.	Ded & Coin.	$25	Ded & Coin.
Specialist Office Visit	$20	Ded & Coin.	Ded & Coin.	$25	Ded & Coin.
Prescription drugs • Retail • Mail Order	$10/$25/$50/$50 N/A	Ded & Coin.	$10/$25/$50/$50 N/A	$10/$25/$50/$50 $25/$62.5/$125/$125	Ded & Coin.
Preventive care	100%	100%	100%	100%	100%
Emergency Room	Ded & Coin.	Ded & Coin.	Ded & Coin.	Ded & Coin.	Ded & Coin.
Actuarial Plan Value	88.7%	76.8%	86.0%	86.2%	82.0%
ER HSA seed	N/A			$1,100,000	
Projected 2019 Gross Cost	$268,696,388			$266,371,359	
Projected 2019 Employee Cost	$22,633,273			$44,280,751	
Projected 2019 Net Employer Cost	$246,063,115			$222,090,607	

Note: benefit levels shown above are for in-network only.

*HDHP deductible and out of pocket maximum are embedded.

Enrollment numbers and projected claims are based on 2019 estimates from Milliman

Proposed assumes 7.5% migration to the HDHP

MEDICAL/RX
PROJECTED CONTRIBUTION DETAIL

Contributions	Current PPO	Current Trad	Current HDHP	Proposed PPO	Proposed HDHP
EE	$47.00	$58.00	$38.00	$90.00	$45.00
EE+SP	$119.00	$144.00	$101.00	$189.00	$94.50
EE+CH	$82.00	$102.00	$68.00	$135.00	$67.50
EE+CHILDREN	$110.00	$133.00	$92.00	$189.00	$94.50
EE+SP and CH	$149.00	$181.00	$126.00	$324.00	$162.00
EE+SP and CHILDREN	$171.00	$202.00	$141.00	$378.00	$189.00

*Current based on 2017 contributions

*Proposed assumes 7.5% migration to HDHP and tier ratios of 1, 2.1,1.5, 2.1 3.6, and 4.2

*Enrollment based on 2019 projected enrollment from Milliman

MEDICAL/RX
FINANCIAL CAVEATS

Mercer has prepared these projections exclusively for State of Idaho, to estimate the range of possibilities related to volatility in health plan claims experience. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available at a point in time and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability from the estimates. Actual variability may differ from this illustration.

SELF-FUNDING FINANCIAL IMPACT ANALYSIS

SELF-FUNDED FINANCIAL IMPACT ANALYSIS
INTRODUCTION

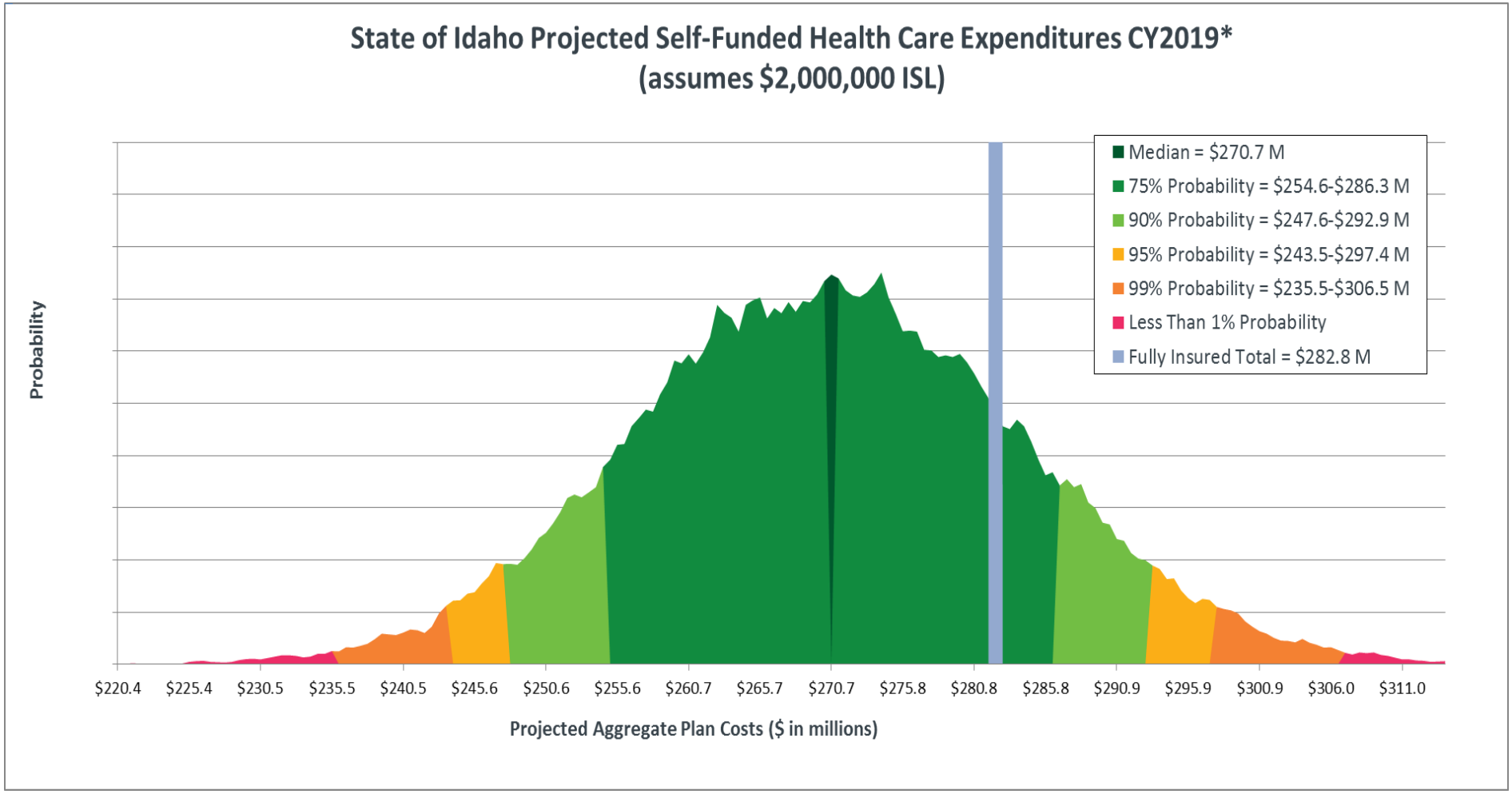
- We completed a financial analysis to estimate the savings under self-funding for the State of Idaho medical/Rx plans
  - Our analysis is based on ***actual*** payments made under the plan during 2016
  - Under self-funding
    - Certain fixed-cost components are removed (e.g. margin, premium tax, ACA fully insured carrier fee
    - Other components remain, but are typically lower under self-funding than under a fully insured arrangement for the same level and scope of services provided (e.g. administrative fees, stop-loss premiums)
  - The following page illustrates our estimate of the savings the State of Idaho would have experienced had the medical/Rx plans been self-funded in 2016
- We are not addressing claims costs in this analysis
  - For a group the size of the State of Idaho, ultimately, the plan pays for the claims experience whether self-funded or fully-insured

PROJECTED SAVINGS FROM SELF-FUNDING

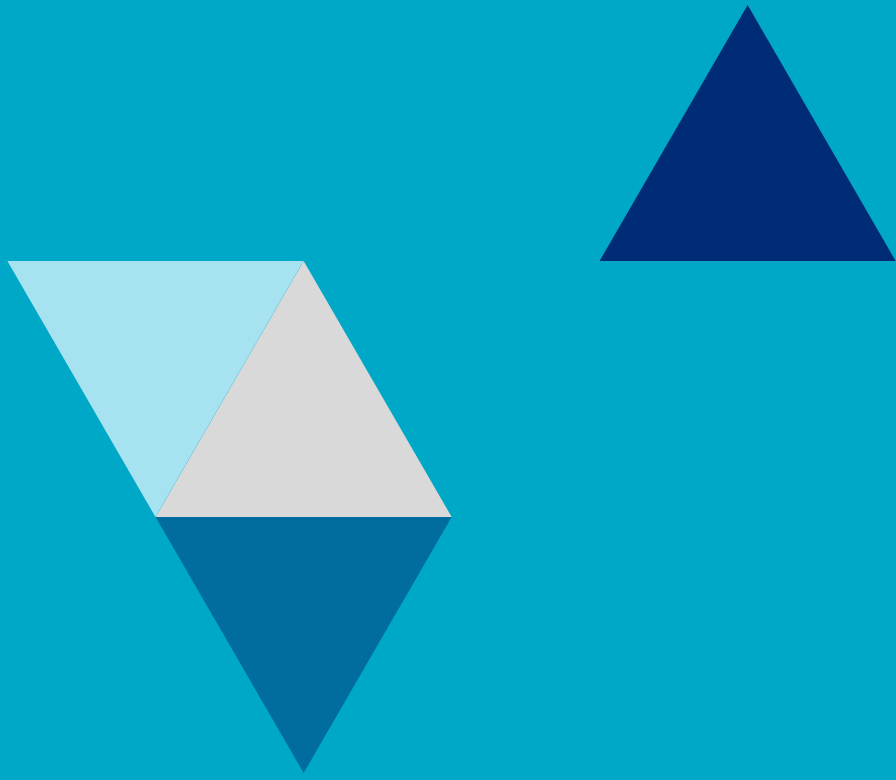
	Fully Insured	Self-Funded
2016 Claims	$1,133.40	$1,133.40
Fixed Costs		
- Administration	$ 43.40	$ 45.16
- Premium Tax	$ 17.65	$ -
- Risk Charge	$ -	$ -
- Health Care Reform Fees	$ 41.42	$ 0.28
- Total PEPM	$ 102.47	$ 45.44
Estimated Enrollment	18,932	18,932
Total	$ 280,770,000	$ 267,813,891
Difference		$ (12,956,109)

- Assumes claims are equal under fully insured and self-funded arrangements
- Costs are based on 2016 actual fully insured costs and estimated self-funded administration costs based on benchmarks
- This estimate is based on 2016 data and required fees to illustrate the difference between the cost of fully insuring and self-funding. Health Care Reform fees are contingent upon legislation and my or may not be required in 2019 as summarized in the following notes.
- Health Care Reform Fees include the following:
  - Transitional Reinsurance Fee – no fee payments required after 2016. As of today this fee will not be in place for 2019
  - PCORI fee – The last PCORI fees will be for plan year 2018 for calendar year plans (paid in 2019).
  - Health Insurance Providers Fee – while there was a 2017 moratorium on this fee, it will continue in 2018 and in its current state will be effective in 2019. This fee is applicable for insured plans only.

SELF-FUNDING VERSUS FULLY INSURED COST



SELF-FUNDING OVERVIEW AND STRATEGY



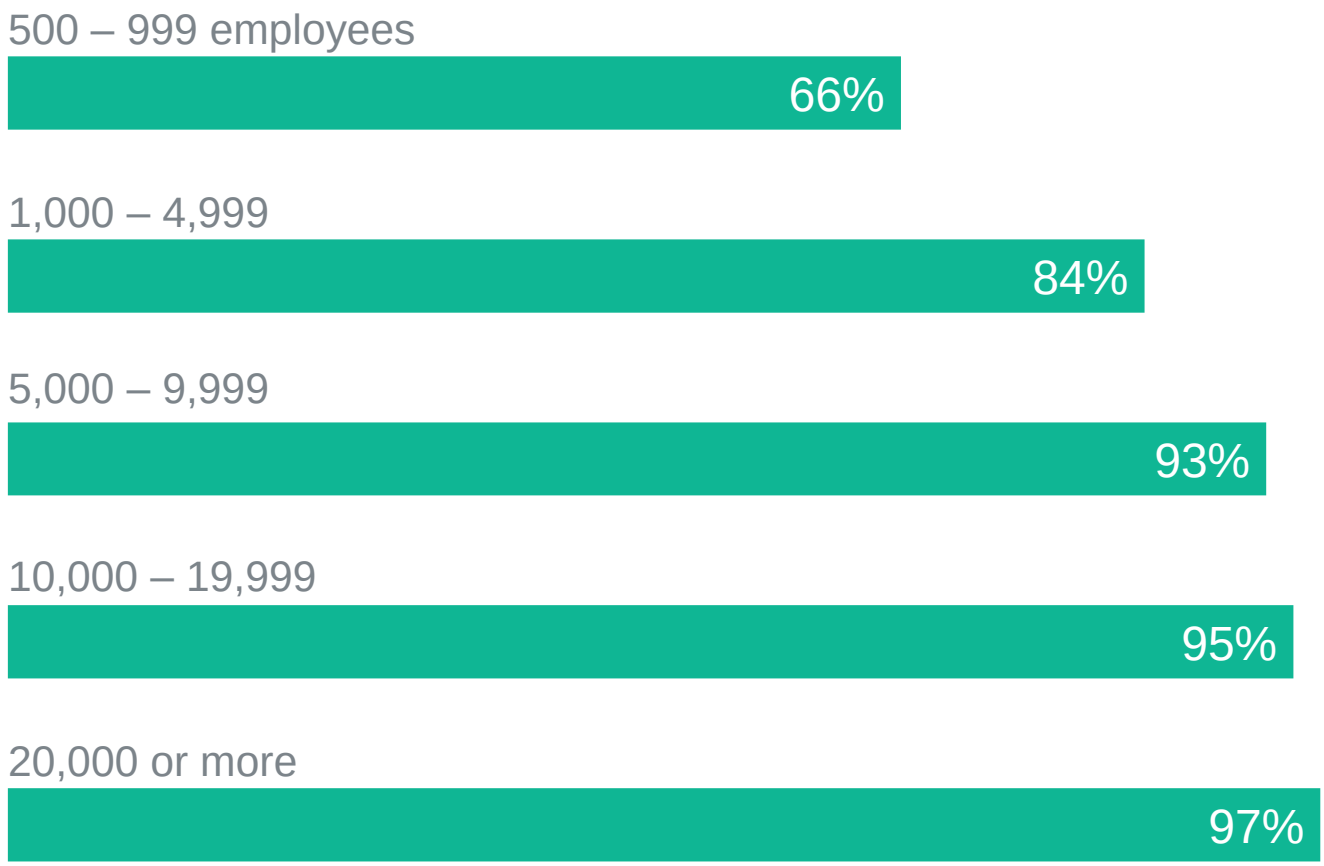
STRATEGY DEVELOPMENT
SELF-FUNDING OVERVIEW & FEASIBILITY REVIEW

Our understanding of the State of Idaho's Employee Group Health Plan situation…

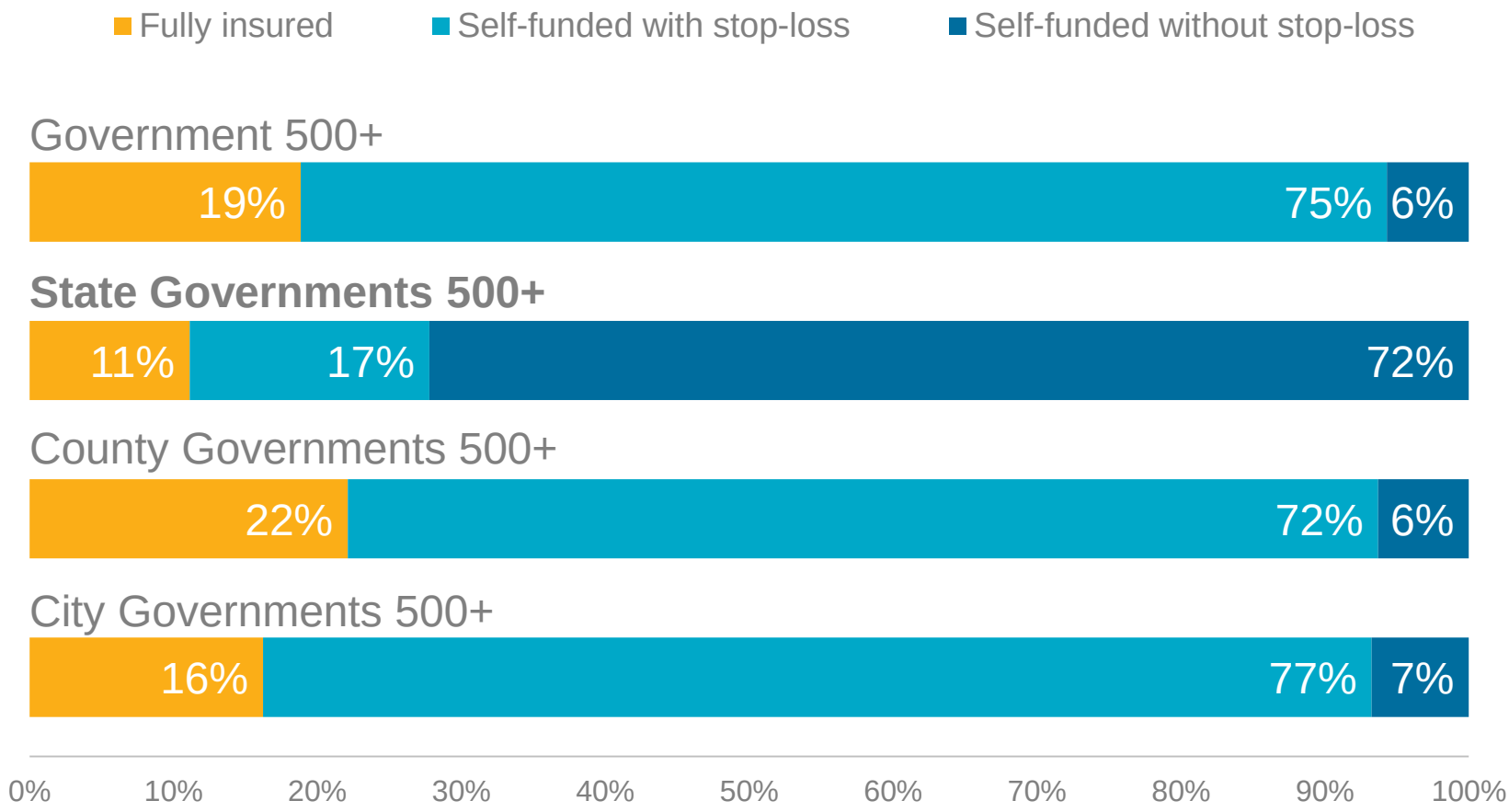
- The State of Idaho's medical plans are currently fully insured with Blue Cross of Idaho
  - Majority of employers, of similar size are self-funded vs fully insured
  - Majority of states are self-funded vs fully insured
  - Current plan management or cost increases are unsustainable
  - Competitive benefits programs are necessary to attract and retain talent
  - Title 41, Chapter 40 has been a barrier to self-funding the State of Idaho's s medical benefits, due to approval and reporting requirements that apply to government entities in the State of Idaho
  - The following slides will provide a brief summary of self-funding and the current State of Idaho requirements
    - We will review your options –
    - Register under Title 41, Chapter 40 as a Single Employer Health Plan
    - Register under Title 41, Chapter 41 as a Joint Public Agency Health Plan
    - Request exemption, change to Idaho Statures for the State

SELF-FUNDING OVERVIEW

SELF FUND MEDICAL PLAN OF ANY TYPE, BY EMPLOYER SIZE



SELF-FUNDING OVERVIEW
GOVERNMENT EMPLOYERS - FUNDING METHOD



SELF-FUNDING OVERVIEW
BENCHMARK DATA-STOP LOSS CENTER OF EXCELLENCE

- Based on the 2014 Mercer Survey, percentage of employers with a self-funded medical plan that carry stop loss:

Covered Employees	200-499	500-999	1,000-4,999	5,000-9,999	10,000-19,999	20,000+
With Stop Loss	92%	94%	89%	69%	63%	25%
Without Stop Loss	8%	6%	11%	31%	37%	75%

- Of those carrying stop loss, percentage of employers with specific coverage or specific and aggregate coverage:

Covered Employees	200-499	500-999	1,000-4,999	5,000-9,999	10,000-19,999	20,000+
Specific Coverage Only	39%	31%	53%	53%	67%	83%
Both Specific and Aggregate Coverage	61%	69%	47%	47%	33%	17%

- Median specific stop loss deductible

Covered Employees	200-499	500-999	1,000-4,999	5,000-9,999	10,000-19,999	20,000+
Specific Stop Loss Deductible	$100,000	$150,000	$225,000	$350,000	$500,000	$500,000

MEDICAL/RX
PROJECTED STOP LOSS DEDUCTIBLE ANALYSIS

Specific Stop Loss Level	Claim Frequency	Average Claims/Year	Avg Amt Above Ded.	Annual Cost	ISL Premium Equivalent (PEPM)	Probability of Reimbursements Being 100% or More of Premiums
$500,000	0.08%	20.4	$431,521	$8,801,998	$53.06	19.58%
$750,000	0.03%	9.1	$591,792	$5,385,548	$32.46	23.50%
$1,000,000	0.02%	5.0	$742,449	$3,698,359	$22.29	24.75%
$1,500,000	0.01%	2.0	$1,028,117	$2,094,891	$12.63	25.01%
$2,000,000	0.00%	1.1	$1,283,549	$1,359,792	$8.20	23.65%

SELF-FUNDING OVERVIEW
INTRODUCTION TO SELF-FUNDING

- Medical, dental and vision plans can be funded in one of two main ways:
  - Fully insured: the insurer assumes the costs and risks and the employer's exposure for the year is fixed
  - Self-funded: a third party provides administrative services for a fee and the employer assumes the costs and risks. Claims expenses are paid from general assets or a trust
  - Some hybrid models available (i.e. mini-max, retrospective premium, level-funding)
- Neither approach is inherently better or worse
- Each has advantages and disadvantages
- Employers make decisions relative to the funding method for many different reasons
  - Typically, decisions are made based on risk tolerance vs. potential gains
- Plan Sponsors/Clients are increasingly asking for guidance in the decision to move from fully insured to self-funded

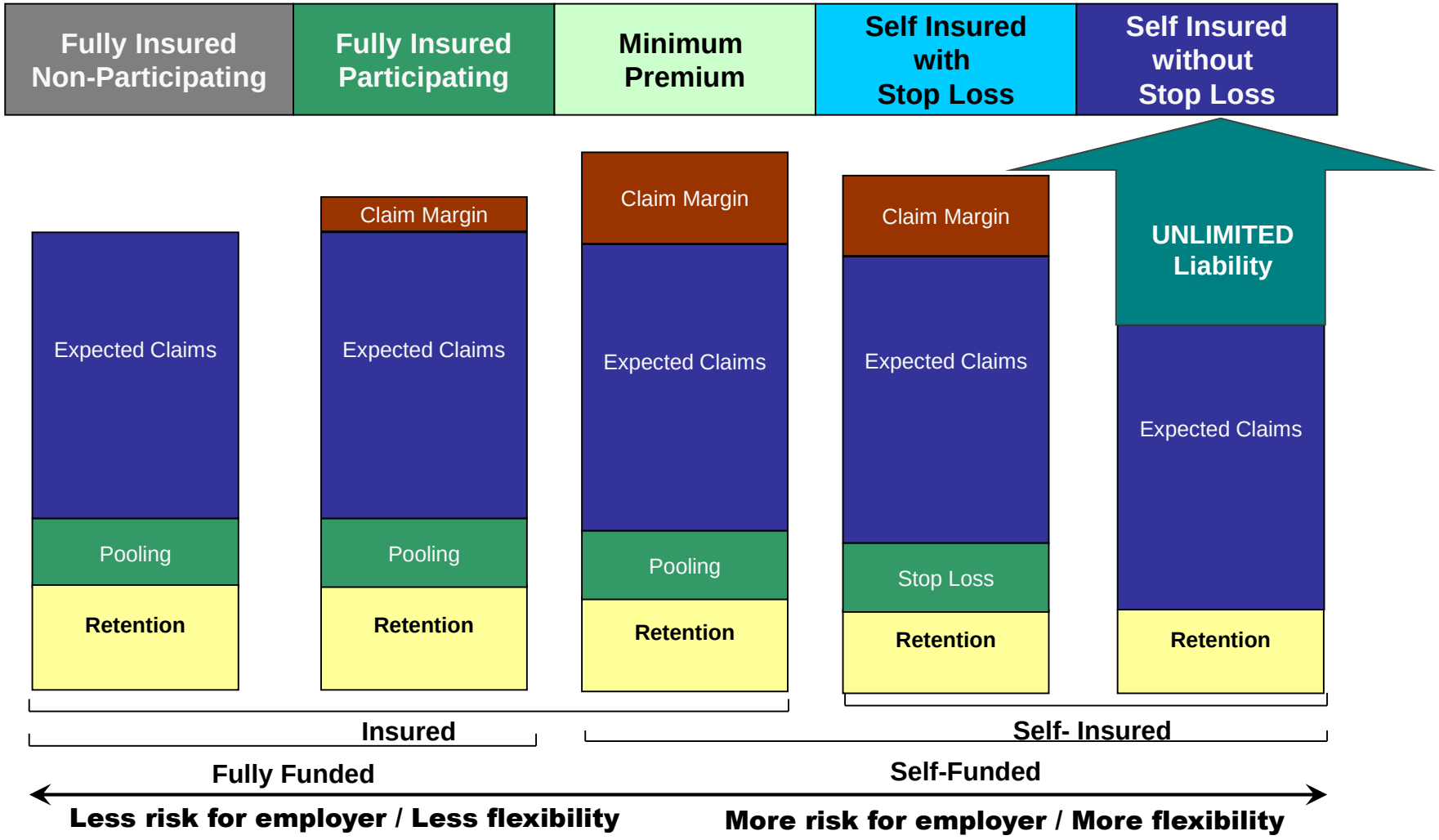
SELF-FUNDING OVERVIEW
INTRODUCTION TO SELF-FUNDING

- How much on average will an employer save with self-funding?
  - Typically 4%-9%
  - These ranges though are over a long-term horizon; over a short-term, self-funding will cost employers more in years where adverse claims materialize
  - Large employers are experience rated, whether self-funded or fully insured
- Plan Administrators have certain responsibilities whether the benefits are insured or self-funded
  - When an employer self-funds, the employer assumes more responsibility for plan design, fiduciary functions, and other compliance responsibilities
  - There are ways to manage or mitigate exposure, but the client should be fully informed and implement appropriate procedures and safeguards

SELF-FUNDING OVERVIEW
SELF-FUNDING DEFINITION

- A self-funded (self-insured) group health plan is one in which the employer assumes the financial risk for providing health care benefits to its employees
  - Plan sponsor bears most or all of the financial risk of the plan
  - Plan sponsor is responsible for the actual costs of services provided under the plan
  - Stop-loss insurance is used to provide employer protection against catastrophic individual claims and/or excess aggregate claims
- Self-funded employers pay for each covered medical expense, out-of-pocket as it is incurred, instead of paying a fixed premium to an insurance carrier
  - All major aspects of the relationship can be unbundled and include a third-party administrator (TPA) or an insurance company on an administrative services only (ASO) basis to process claims
  - Plan sponsor may carve out certain services (e.g. care management, disease management, pharmacy benefit management, etc.)

SELF-FUNDING OVERVIEW
HEALTHCARE FUNDING OPTIONS – COST COMPONENTS



SELF-FUNDING OVERVIEW
WHY SELF-FUND?

- As a group increases in size, historical claims become a more credible predictor of future claims. Thus, the risks involved in self-funding medical benefits reduce as a group grows in size.
- Self-funding can improve cash flow because you are not required to make conventional premium payments. You may delay payment until it is actually needed to pay claims.
- Earn interest on Incurred But Not Reported (IBNR) reserves maintained by the employer
- Eliminate state premium tax and other state and Federal (ACA) assessments
- Potential for “Best of the Best” vendor partners (i.e. Administrator, Network, Reinsurance Carrier, PBM, Care Management and Wellness partners)
- Potential to beat the carrier’s fully-insured claims “trend”
- Statistics in Plan Sponsor’s favor
- Flexibility and control over your plan design
- Avoid certain legislative requirements`

SELF-FUNDING OVERVIEW
PROS & CONS OF SELF-FUNDING

Pros

- Cash flow
- Reduced administration and retention costs
- Plan design flexibility and control
- “Profits” to employer
- Ability to make claims decisions
- Not subject to most state mandated benefits
- Employer holds reserves - ROI
- Expanded availability of reporting
- Eliminate state premium taxes and assessments
- Minimal impact on plan participants
- Stable workforce-more predictable claims

Cons

- Claims fluctuations
- Potential increased financial risk
- Costs are not as predictable on a monthly basis
- More involvement required by employer’s Human Resource and/or Finance Staff
- HIPAA compliance responsibility
- Legal and fiduciary responsibility

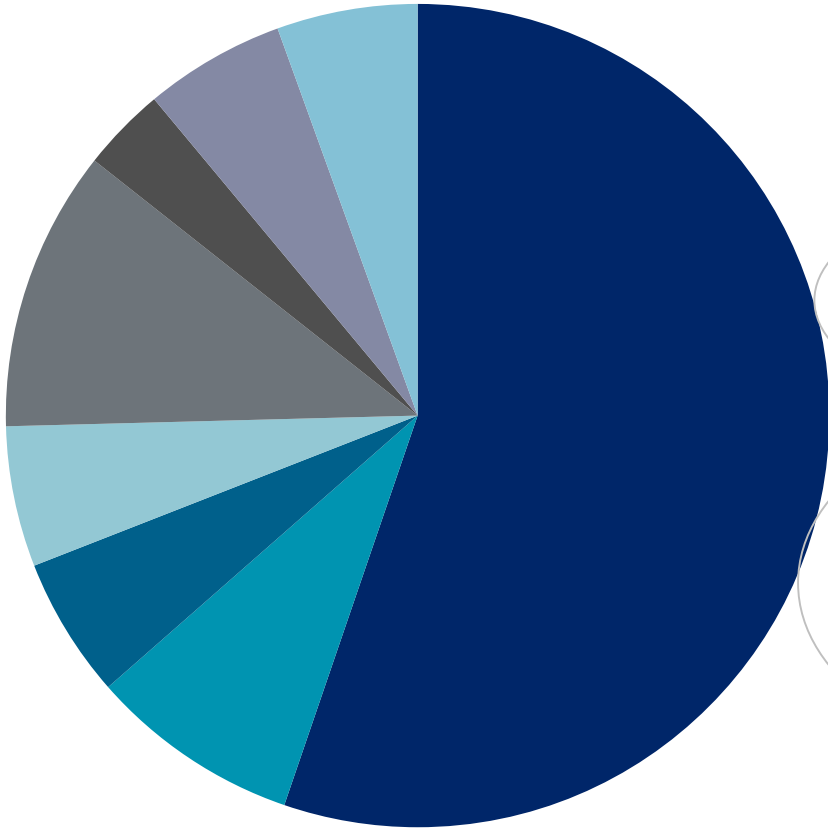
SELF-FUNDING OVERVIEW
BUDGETING FOR A SELF-FUNDED PLAN

- In a fully insured arrangement, the insurer establishes the premium rates
  - The role of the employer and/or broker is to negotiate the best premium rate possible
  - Requires less involvement from the broker, HR, and finance
- Under self-insurance, the employer and/or broker develop budgeted rates, also called premium equivalents
  - The process of setting self-funded rates is straightforward, although it will typically require more time and input from the parties involved
  - Components include all fixed costs/admin expenses, expected claims, and margin (optional)
  - The plan sponsor/broker is also responsible for setting IBNR reserves for the self-funded plan

BUDGETING IN A SELF-FUNDED -*CONTINUED*

- Why do we calculate premium equivalents?
  - Basis for setting employee contributions
  - Basis for projecting total plan costs/setting budgets
  - Required to set COBRA rates
- While more time is involved from the plan sponsor, the increased flexibility in budgeting is an advantage
  - Plan sponsor's HR and finance departments can determine the acceptable level of conservatism (trend factors, margin component, etc.)

SELF-FUNDING OVERVIEW
UNDERSTANDING EXPENSES/FIXED COSTS



- Administrative charges
- Network access fees
- Utilization and case management
- Disease management
- Risk charge
- State premium tax
- ACA fully insured fees
- Profit

Plan sponsor decides whether the services are worth paying for…or carves them out

Eliminated under self-funding (premium tax only applies to stop-loss premiums)

Note: chart is illustrative; components are not to relative scale.

SELF-FUNDING OVERVIEW
UNDERSTANDING TREND IN HEALTHCARE

Factors Driving Rising Cost of Healthcare Premiums

MERCER 2017 – Active Ranges	Low	High	
Medical Trend		4%	7.5%
• Fully Insured (w/margin)	4.5%	9%	
Prescription Drug Trend	8%	13%	

Trend Factors

- General Inflation
- Technology/Advances
- Rising Provider Expenses
- Government Mandates, Regulations
- Demographics
- Utilization
- Litigation & Risk Management
- Fraud & Abuse

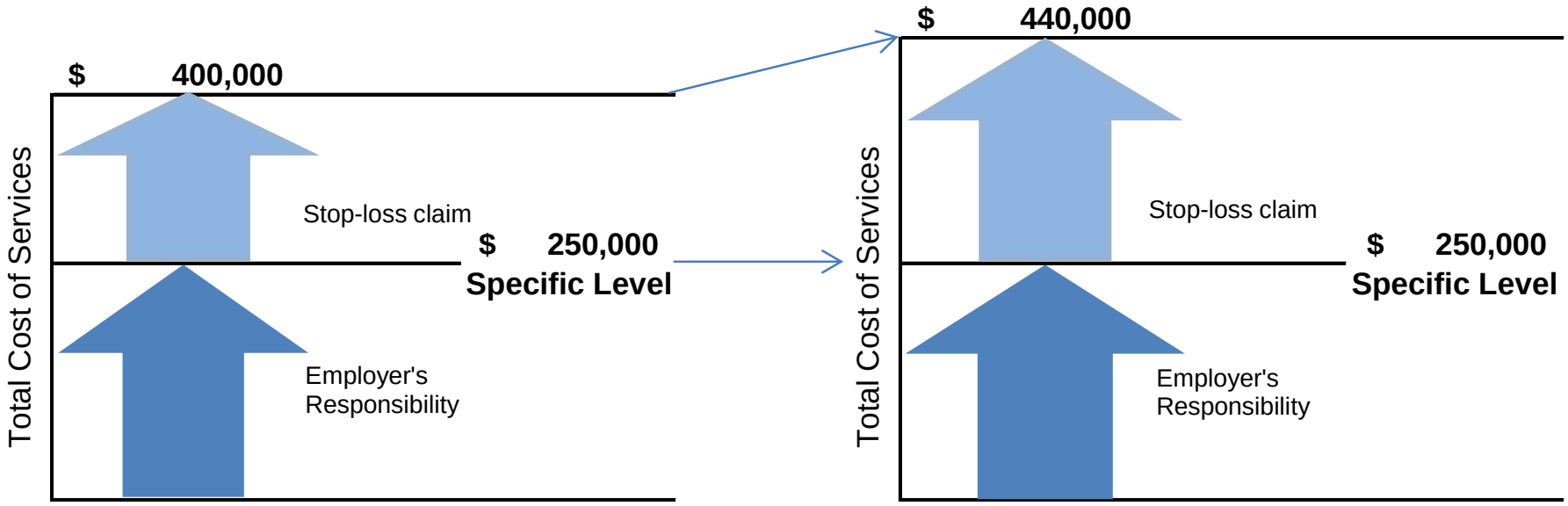
*The impact of a change in trend factors on liabilities depends upon the current trend factor, population demographics, methods of claim cost development and plan design, among other things. The impact on any given plans liability will vary when the new factors are adopted.

SELF-FUNDING OVERVIEW
UNDERSTANDING LEVERAGED TREND

Leveraged Trend reflects the impact of maintaining the same individual deductible from one plan year to the next after accounting for the underlying medical trend on all claims

- Most stop loss carriers will reference leveraged trend as the primary reason for the renewal increase on a given case
- Leveraged trend supports increasing the individual deductible every 2-3 years. Otherwise, the employer is purchasing more stop loss relative to the total expected claims.

SELF-FUNDING OVERVIEW
UNDERSTANDING LEVERAGED TREND - EXAMPLE



Year 1		
Specific Deductible	$	250,000
Total Claim	$	400,000
Stop-loss Claim	$	150,000

Year 2		
Specific Deductible	$	250,000
Total Claim-with 10% trend	$	440,000
Stop-loss Claim	$	190,000

Stop-loss Claim % Increase	**27%**

SELF-FUNDING OVERVIEW
RISK MODERATION– STOP LOSS

- To reduce claims liability, employers frequently purchase stop-loss insurance: aggregate, specific or both
  - **Specific stop-loss**
    - Limits employer's claim exposure for benefits paid on behalf of any covered claimant during the year
      - Plan eligibility provisions and definition of covered participants is important!
    - Deductibles will vary based upon the size of the group and expected claims projections
    - To minimize risks further, individual deductibles can be low ($75,000 – $150,000 per person per year)
  - **Aggregate stop-loss**
    - Limits employer's overall liability for total claims within the term of the contract (12 months)
    - Based upon expected claims plus a corridor (typically expected claims x 1.20 to 2.00)
    - Can include monthly maximum exposure feature to limit employer's exposure

SELF-FUNDING OVERVIEW
BASIC CONCEPTS – CONTRACT BASIS

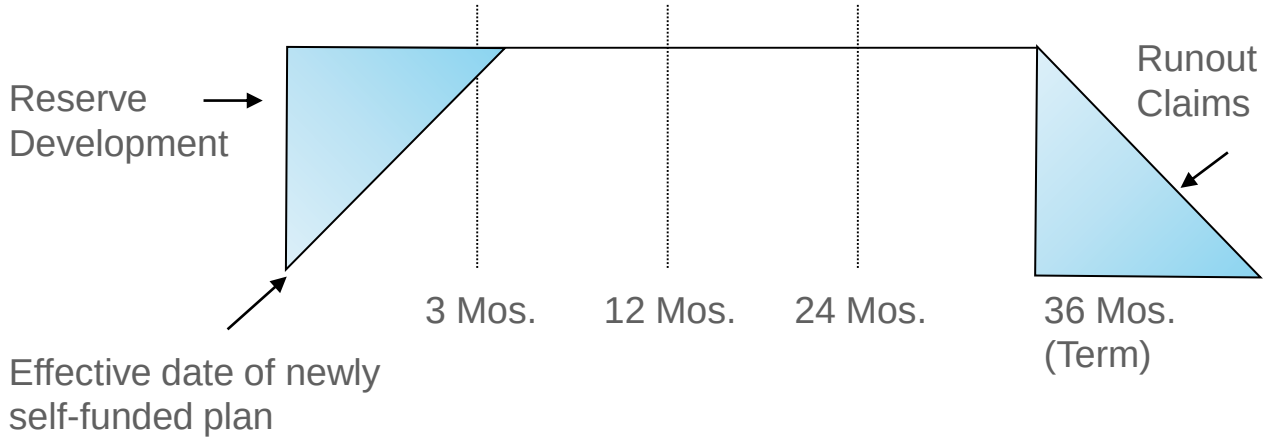
	Contract Basis Description	Incurred Time Period	Paid Time Period	Potential Gap in Coverage
Paid	Covers all claims paid in the contract year, regardless of when the claim is incurred. Generally available on renewal but not year one of a contract	Any date	12 months 1/1/15 – 12/31/15	None
24/12	Covers all claims paid in the contract year that are incurred during the 24-month period beginning 12 months before the contract year begins	24 months 1/1/14 – 12/31/15	12 months 1/1/15 – 12/31/15	Incurred prior to 1/1/14
18/12	Covers all claims paid in the contract year that are incurred during the 18-month period beginning 6 months before the contract year begins	18 months 7/1/14 – 12/31/15	12 months 1/1/15 – 12/31/15	Incurred prior to 7/1/14
15/12	Covers all claims paid in the contract year that are incurred during the 15-month period beginning 3 months before the contract year begins	15 months 10/1/14 – 12/31/15	12 months 1/1/15 – 12/31/15	Incurred prior to 10/1/14
12/12	Covers all claims paid and incurred during the contract year (generally recommended only for the first year of coming off a fully-insured contract and where the client plans to utilize a paid / run-in contract in year two and beyond)	12 months 1/1/15 – 12/31/15	12 months 1/1/15 – 12/31/15	Any claim not incurred AND paid within CY 2015
12/15	Covers all claims incurred in the contract year and paid up to 6 months after the contract year ends	12 months 1/1/15 – 12/31/15	15 months 1/1/15 – 3/31/16	Incurred CY 2015 but paid after 3/31/16
12/18	Covers all claims incurred in the contract year and paid up to 6 months after the contract year ends	12 months 1/1/15 – 12/31/15	18 months 1/1/15 – 6/30/16	Incurred CY 2015 but paid after 6/30/16
12/24	Covers all claims incurred in the contract year and paid up to 12 months after the contract year ends	12 months 1/1/15 – 12/31/15	24 months 1/1/15 – 12/31/16	Incurred CY 2015 but paid after 12/31/16

Paid / Run-in Contract

Incurred / Run-out Contract

SELF-FUNDING OVERVIEW
CASH FLOW TIMING AT BEGINNING AND END

- First year costs are “immature” due to lag in claim payments (first year medical costs may be 18% to 20% lower than a mature year) resulting in approximately 10 months of mature incurred and paid claims
  - Reduction in first year expense will help “fund” reserves (Incurred But Not Reported claims – IBNR)
  - Self funded plan sponsors must book this liability
- Employer gains benefit of float (weekly/monthly funding and IBNR)
- Second year costs are mature (i.e., twelve months of paid claims and expenses)



SELF-FUNDING OVERVIEW
COMPLIANCE CONSIDERATIONS

General Compliance Considerations

- Fiduciary designations
- H&W and Cafeteria Plan Documents
- Claims and Appeals processes and fiduciary delegations
- Federal mandates: ACA, Mental Health Parity
- Government reporting (Annual Report ; ACA Reporting; W-2 reporting)
- Taxation
  Nondiscrimination testing
- Trust obligations, if funded

Communications

- Summary Plan Descriptions
- Summary of Benefits and Coverages
- Summary of Material Modifications
- Summary of Material Reductions in Benefits
- Summary Annual Reports
- Open Enrollment Materials
- Required Notices

HIPAA Compliance

- HIPAA Privacy
- HIPAA Security
- HIPAA Training
- Business Associate Agreements
- HIPAA Breach Analysis and Reporting

Other State and Federal Laws

- New York Surcharge
- Medicare Primary and Secondary Payer
- Service Contract Act and Governmental Contracting limitations

Exposure

- Increased exposure to claims litigation
- Fiduciaries can be named as defendants
- Privacy and security of PHI
- Opportunity to authorize claim payment
- Assistance to employees
- Plan asset regulations: misuse of assets, reversion of trust assets

SELF-FUNDING OVERVIEW
PLAN MANAGEMENT – IMPACT ON STAFF

- In general, the impact on the staff managing the plans is not significant, and we generally don't see differences in HR and finance staffing between fully-insured and self-funded plans
- But there are some additional requirements:

Human Resources

- Need to pay more attention to the plan design and set up since any requests for an exception and/or gray areas that come up will be resolved by HR rather than the insurance carrier (this can be passed back to the administrator if the administrator is made fiduciary, usually for a fee)
- Need to understand how the plan is running compared to budgeted cost to be prepared to talk to finance, the CFO or VP of HR if questions arise
- Need to add a HIPAA officer, who can see claim details, if needed

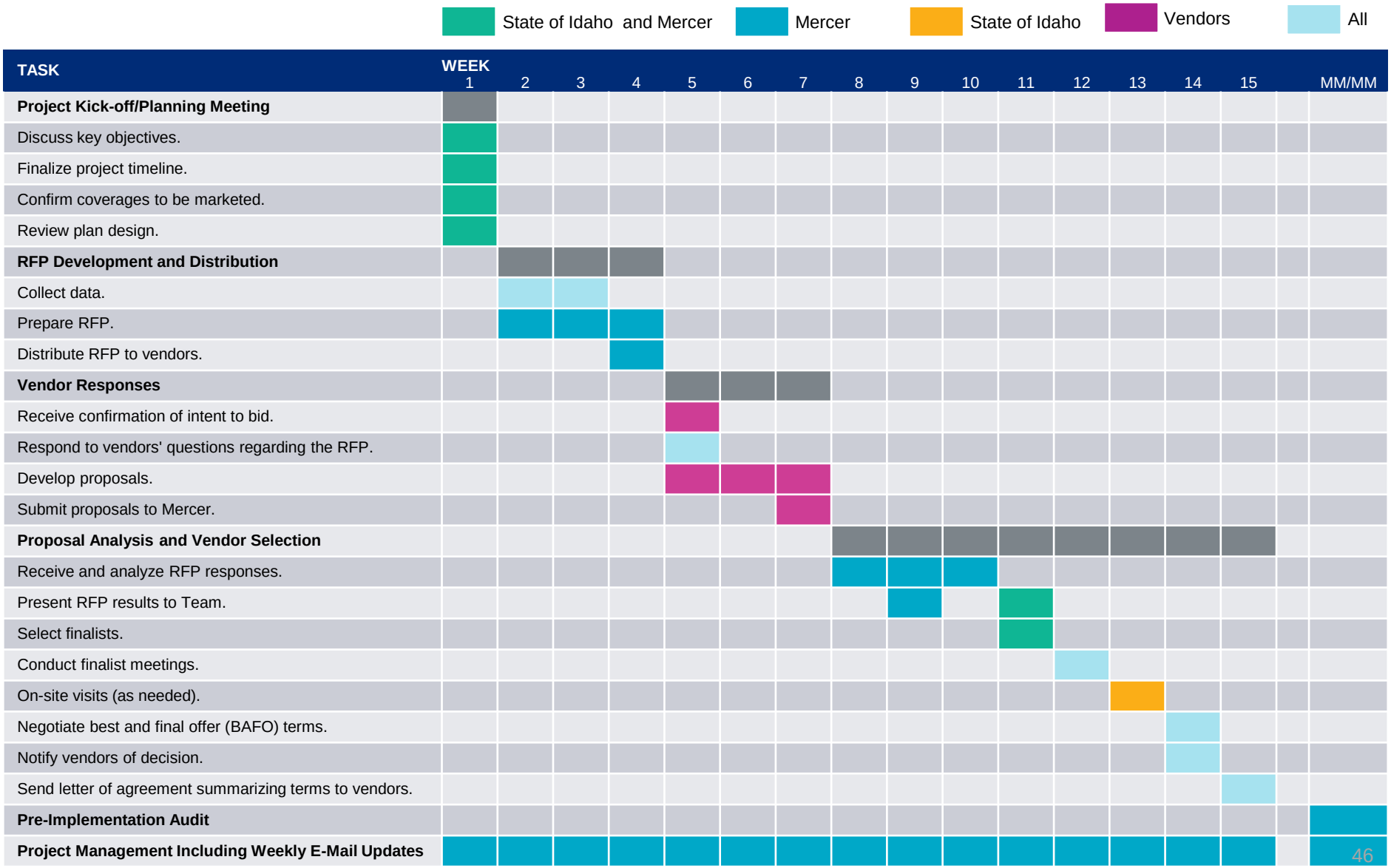
Finance

- Set-up of bank account for claim payment (and possibly for admin fee payment), which typically allows administrator to make an ACH sweep of the account
- Reconcile withdrawals from bank account to claim reports (including large claim reimbursements)
- Understand and account for IBNP
- Understand any withdrawal limits on the bank account and have a contingency for any claim runs that exceed that amount
- Understand and maintain any seed money or minimum balances required for the bank account

SELF-FUNDING OVERVIEW – STATE OF IDAHO
TRANSITION CONSIDERATIONS

- First year stop-loss fees are immature, reflecting that the employer is only liable for claims incurred on or after the effective date of the self-insured plan year
- Second year stop-loss fees will be 35%-50% higher based on providing coverage for a full 12 month period, plus the normal trend adjustment
  - In the transition from fully-insured to self-insured, the insurer is liable for all claims incurred prior to January 1 and the employer is liable for claims incurred on or after that date
  - Thus, the first year stop-loss contract is on a 12/12 basis (claims incurred and paid in 12 months)
  - In the second year under self-funding, the stop-loss contract will change to a paid basis (claims paid during the 12 month contract period regardless of incurred date)
- Employer will need to establish an IBNR reserve in year one of self-funding to fund the outstanding liability in the event of future plan termination
  - This can be achieved through the use of utilizing mature funding rates in the first year under self-insurance

SELF-FUNDING OVERVIEW – STATE OF IDAHO
VENDOR MARKETING SAMPLE TIMELINE



SELF-FUNDING REQUIREMENTS FOR PUBLIC SECTOR EMPLOYERS IN IDAHO

SELF-FUNDING REQUIREMENTS FOR GOVERNMENTAL ENTITIES

Idaho Code - Title 41 Insurance, Chapter 40 - Self-funded Health Care Plans

Governmental and/or Church Plans are not subject to ERISA. This code is applicable to every self-funded health plan that provides fully or partially self-funded health benefit plans to Idaho residents except for single employer plans (which are preempted by federal ERISA law), counties, or those plans otherwise exempted by Idaho Code §41-4003(2).

Governmental plan sponsors, such as the State, cities, school districts, etc. are subject to DOI oversight and must register with the DOI. Annual requirements include:

- Quarterly financial statements are due 60 days after each quarter-end (may be unaudited)
- Annual audited financial statements are due 90 days after the plan's fiscal year-end
- Annual certified actuarial opinion
- Annual continuation fee of $500 and Annual taxes of $0.04 per beneficiary

The Registration process for a single or multiple employer self-funded plans must file the following documents with the director for his review and approval not less than thirty (30) days before the effective date:

- An actuarial study as described in section 41-4005(2)(e), Idaho Code, calculating new rates for the next plan year or more frequent period if there are any midterm rate changes;
- Any changes in the policy form, benefits or summary plan description;
- Any amendments or changes made to the stop-loss agreement or agreements, including change of carriers;
- Any amendments or changes made to administrative, service or management agreements;
- Any amendments or changes to the fidelity bond or other coverage the director deemed equivalent pursuant to section 41-4014(3), Idaho Code;
- Any amendments or changes to the trust agreement; and any change in the trustee or trustees, officers or management of the trust, which notice shall include biographical affidavits of any new trustee, officer or management personnel.

SELF-FUNDING REQUIREMENTS FOR GOVERNMENTAL ENTITIES

Idaho Code - Title 41 Insurance, Chapter 40 - Self-funded Health Care Plans

The Registration Requirements for filing:

- Application (signed by Trustee under oath) included fee-$500.
- Copy of Irrevocable Trust agreement
- Written Benefits Statement (w/rates) – do not use any insurance terms
- All marketing or solicitation materials

Trust not in existence prior to effective date of Registration:

- Pro-Forma Balance Sheet, by month, required for the first 12 months of operation. Projected IBNP/IBNR, Certified by Actuary. Must include ,1) a detailed list of the type and amount of investments of the plan; 2) reserves for claims and other items and 3) other liabilities. All actuary certified.
- Written Statement, projections by month, income and disbursements for 1st 12 months. (Actuarial certification). Trust must have surplus to cover fluctuations in expenses and claims and still meet minimum surplus requirements.
- Business Plan-Include initial funding, in addition to monthly contributions (cannot be loan or prepayment)
- Actuarial Study (Actuarial Certification). Includes, rates, contributions (employer%/ee %), timeframe.
- Self-funded Study or guidance by consultant.
- All contracts or agreements (ASO, Stop-loss, SPD's, rate tables, rating methodology)
- All Plan Sponsor documents, including bylaws, other. agreements. All names of those responsible, for management ,including Bio affidavits for Trustees (form prescribed by the director,) with original signatures and notarizations.
- Certified fidelity bond
- Information Statement
- Required meeting with the DOI to requirements of the code, and plan compliance

SELF-FUNDING REQUIREMENTS FOR GOVERNMENTAL ENTITIES

Idaho Code - Title 41 Insurance, Chapter 41- Self-funded Health Care Plans

This Code is applicable to all self-funded plans established by public agencies pursuant to a joint powers agreement in accordance with Chapter 23, Title 67, Idaho Code, for provision of health care service benefits to employees of public agencies in connection with or as an alternative to insurance and other prepayment plans. . Annual requirements include:

- Quarterly financial statements are due 60 days after each quarter-end (may be unaudited)
- Annual audited financial statements are due 90 days after the plan's fiscal year-end
- Annual certified actuarial opinion
- **No annual continuation fee and no Annual taxes**

The Registration process for a single or multiple employer self-funded plans must file the following documents with the director for his review and approval not less than thirty (30) days before the effective date:

- An actuarial study as described in section 41-4005(2)(e), Idaho Code, calculating new rates for the next plan year or more frequent period if there are any midterm rate changes;
- Any changes in the policy form, benefits or summary plan description;
- Any amendments or changes made to the stop-loss agreement or agreements, including change of carriers;
- Any amendments or changes made to administrative, service or management agreements;
- Any amendments or changes to the fidelity bond or other coverage the director deemed equivalent pursuant to section 41-4014(3), Idaho Code;
- Any amendments or changes to the trust agreement; and any change in the trustee or trustees, officers or management of the trust, which notice shall include biographical affidavits of any new trustee, officer or management personnel.

SELF-FUNDING REQUIREMENTS FOR GOVERNMENTAL ENTITIES

Idaho Code - Title 41 Insurance, Chapter 41- Self-funded Health Care Plans

The Registration Requirements for filing:

- Application (signed by each authorized official for Public Agency and 1 Trustee). No Fee
- Copy of Irrevocable Trust agreement
- Written Benefits Statement (w/rates) – do not use any insurance terms
- All marketing or solicitation materials

Trust not in existence prior to effective date of Registration:

- Pro-Forma Balance Sheet, by month, required for the first 12 months of operation. Projected IBNP/IBNR, Certified by Actuary. Must include ,1) a detailed list of the type and amount of investments of the plan; 2) reserves for claims and other items and 3) other liabilities. All actuary certified.
- Written Statement ,projections by month, income and disbursements for 1st 12 months. (Actuarial certification). Trust must have surplus to cover fluctuations in expenses and claims and still meet minimum surplus requirements.
- Business Plan-Include initial funding, in addition to monthly contributions (cannot be loan or prepayment)
- Actuarial Study (Actuarial Certification). Includes, rates, contributions (employer%/ee %), timeframe.
- Self-funded Study or guidance by consultant.
- All contracts or agreements (ASO, Stop-loss, SPD's, rate tables, rating methodology)
- Joint Powers Agreement. All documents, including bylaws, other. agreements. All names of those responsible for JPA Plan management ,including Bio affidavits for Trustees.
- Certified Surety bond on all involved individuals and trustees
- Information Statement
- Required meeting with the DOI to requirements of the code, and plan compliance

SELF-FUNDING REQUIREMENTS FOR GOVERNMENTAL ENTITIES

COMPARING MAJOR DIFFERENCES

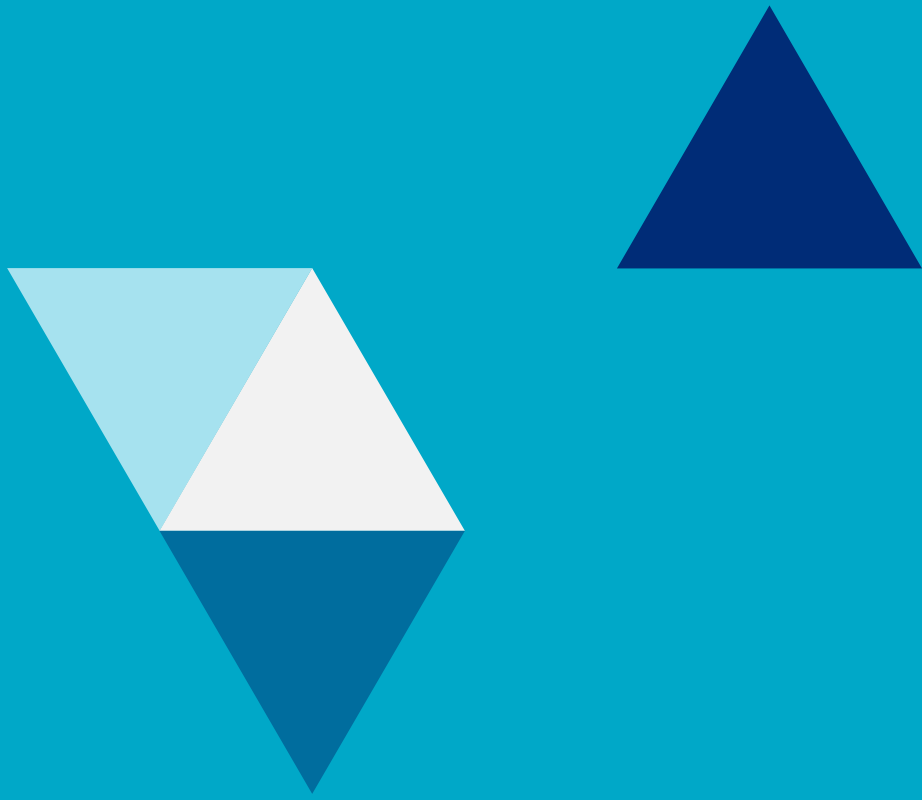
	Chapter 40-Single/Multi Employer	Major Differences		Chapter 41- Gov Plans, Joint Powers	Major Differences
41-4003	REGISTRATION REQUIRED -EXEMPTIONS-NOT SUBJECT TO INSURANCE CODE.	-Deductible buy-downs under $5k exempt -Aggregate $'s under$500k	41-4003	REGISTRATION REQUIRED EXEMPTIONS-NOT SUBJECT TO INSURANCE CODE.	Buy-downs not exempt
41-4005	APPLICATION FOR REGISTRATION - FEE.	Yes, $500	41-4005	APPLICATION FOR REGISTRATION - FEE.	No fee
41-4010	RESERVES AND SURPLUS.	1)Quarterly adjustment to reserves 2)Minimum Surplus -3 months cont. or -110% of difference of agg factor + opp costs and expected costs	41-4010	RESERVES	1) No Quarterly Adjustment 2) No required Surplus
41-4011	RECORDS AND ACCOUNTS- ANNUAL STATEMENT.	Annual Acctg and Certified Actuarial	41-4011	RECORDS AND ACCOUNTS-ANNUAL STATEMENT.	Annual Accounting only
41-4012	TAXES.	$.40/PMPB	41-4012	TAXES.	Exempt Taxes
41-4024	SERVICES PROVIDED BY GOVERNMENTAL ENTITIES.	Benefits cannot be reduced due to increase in Medicare Payments	41-4124	SERVICES PROVIDED BY GOVERNMENTAL ENTITIES.	Benefit reductions due to increase in Medicare benefits **not** prohibited

NEXT STEPS

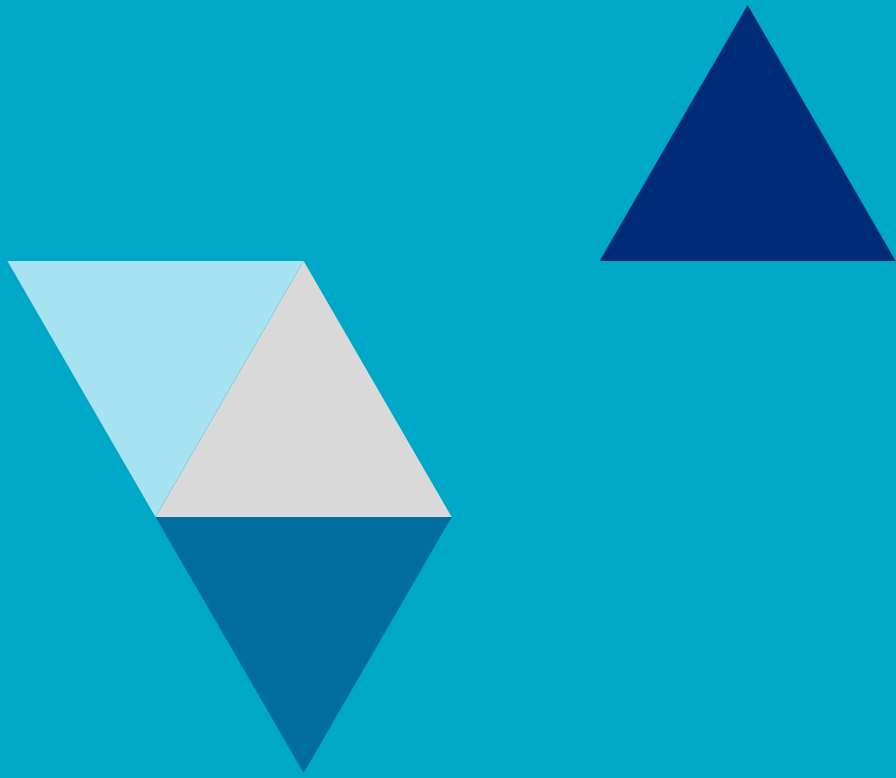
NEXT STEPS

- Adjust strategic roadmap and financial analysis based on feedback
- Meeting #4 scheduled for October 19th, agenda to include:
  - Presentation of revised strategic roadmap
  - Presentation of revised financial analysis estimating the cost impact of changes and strategies under consideration
- Other?

APPENDIX



PRIORITIZATION OF ADDITIONAL OPPORTUNITIES



PRIORITIZATION OF ADDITIONAL OPPORTUNITIES

$ = 0% - 2% savings
$$ = 3% - 5% savings
$$$ = 5% - 10% savings

Feature	Considerations for Optimization	Potential Results
Value Based Care (VBC) strategy	• Exploration to include Accountable Care Organization (ACO), Patient Centered Medical Home (PCMH), Regional Care Model, Direct Primary Care (DPC) options • Explore possibility of leveraging PCMH network being developed under the Idaho SHIP program • Include plan design steerage to incent utilization of high value providers	$$-$$$
Telemedicine	• Target 10%-15% Utilization • Reduce costs at PCP, Urgent Care and Emergency room • Improved productivity	$
Care management	• Explore care and disease management options through carriers and through third party vendors • Implement best in class program	$

PRIORITIZATION OF ADDITIONAL OPPORTUNITIES

$ = 0% - 2% savings
$$ = 3% - 5% savings
$$$ = 5% - 10% savings

Feature	Considerations for Optimization	Potential Results
Expert Medical Option (EMO)	• Implement EMO program to improve diagnosis, treatment decisions, and outcomes for those with complex diagnosis and high cost claims	$
On-site/near-site clinics	• Explore on-site/near-site clinic options to supplement VBC providers	$-$$
Centers of Excellence (COE)	• Implement COE solution and/or bundled payments through a vendor or via direct contracting to achieve better surgical costs and outcomes (ortho, cardiac, etc.)	$
Potential to integrate State Employee population into Medicaid, with Medicaid Fee Schedule or reimbursement	• Join Medicaid population, fund reimbursements at Medicaid rates. • CMS Approval for addition of population and increased fee reimbursement to offset commercial reimbursement.	$$

PRIORITIZATION OF ADDITIONAL OPPORTUNITIES

$ = 0% - 2% savings
$$ = 3% - 5% savings
$$$ = 5% - 10% savings

Feature	Considerations for Optimization	Potential Results
Well-being	• Implement evidence based well-being programs with outcomes-based incentives	$-$$
Targeted point solutions	• Implement best-in-class point solutions to address weight management/diabetes prevention, cancer, maternity, and musculoskeletal	$-$$
Tobacco surcharge	• Implement tobacco surcharge of $50-$100 per month (via affidavit)	$

PRIORITIZATION OF ADDITIONAL OPPORTUNITIES

$ = 0% - 2% savings
$$ = 3% - 5% savings
$$$ = 5% - 10% savings

Feature	Considerations for Optimization	Potential Results
Transparency	• Implement transparency solution to allow employees and their families to shop for high quality, lower cost care	$-$$
Advocacy	• Explore advocacy solutions to provide a resource for employees and their families to better navigate the health care system	$-$$
Salary-based strategies	• Explore salary based contributions and/or account contributions as a means to address affordability for employees	$
Spousal surcharge	• Implement spousal surcharge for those with access to other coverage of $50-$100 per month (via affidavit)	$
Retiree Options	• Retiree options, outside of the State of Idaho Programs • Retiree Exchange Opportunities	$-$$

PRIORITIZATION OF ADDITIONAL OPPORTUNITIES

$ = 0% - 2% savings
$$ = 3% - 5% savings
$$$ = 5% - 10% savings

Feature	Considerations for Optimization	Potential Results
Life Insurance Plan Management	• Conduct RFP for Life Insurance, both employer paid and voluntary benefits • Best Practices Approach • Enhance benefit offerings • Reduce overall costs	$-$$
Disability Insurance Plan Management	• Conduct RFP for Short-term and Long-term Disability • Potential for Base and Buy-Up options • Best Practices Approach • Enhance benefit offerings • Reduce overall costs	$-$$
Review opportunity to introduce Voluntary Benefit Offerings	• Enhance benefits offering with VB Options • Enhance Employee Choice	$
Review all other Current or Future Benefit Offerings	• TBD	$

PRIORITIZATION OF ADDITIONAL OPPORTUNITIES

$ = 0% - 2% savings
$$ = 3% - 5% savings
$$$ = 5% - 10% savings

Feature	Considerations for Optimization	Potential Results
Medical plan management	• Conduct RFP for medical plan administration including conversion to self-funding	$-$$
Pharmacy plan management	• Explore savings opportunities through Mercer Rx collective savings • Improved contract terms • Implement care management features • Explore Specialty Pharmacy management options, including the potential for a Specialty Rx tier	$-$$
Introduction of a catastrophic plan	• Not designed to drive meaningful cost savings, but to offer true expanded choice and a very low cost or no cost option	$
Dental and vision plan management	• Conduct RFP for dental and vision plan administration including conversion to self-funding	$

GUIDING PRINCIPLES

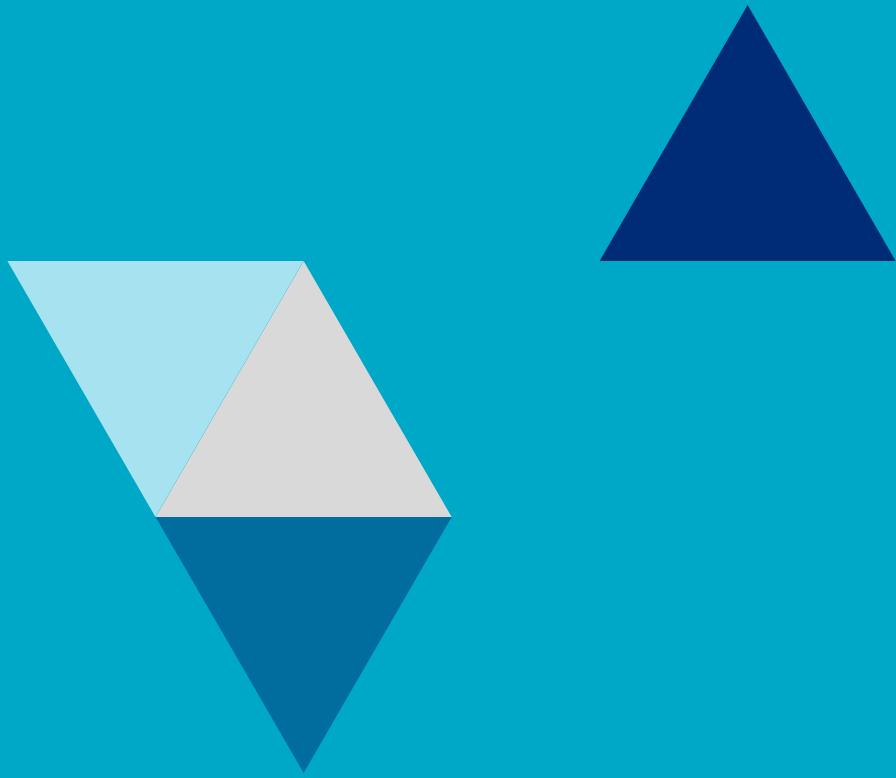
DRAFT GUIDING PRINCIPLES
CURRENT VS. DESIRED FUTURE STATE

Guiding Principles	Current State	Objectives/Future State
Market Position	• Current medical plans are generally more generous than market • Company is not an early adopter of new strategies	• Benefits targeted at market median with a paramount focus on affordability both for employees and for taxpayers, who fund the program • Open to early adoption of new programs/strategies but proof of concept is required – future strategies need to be evidence-based
Company Budget (Cost-sharing Approach)	• No set strategy; decisions are based upon year-over-year cost increase and budget	• Company cost growth to be managed proactively • More cost shift through plan design while maintaining protection for catastrophic events • Manage health care costs through greater focus on health improvement and appropriate use of health care services
Program Eligibility	• Programs provide a safety net for all employees • Company subsidy does not vary based on pay or job level • Modest differences in employee contribution requirements between plans • Dependents are subsidized at a slightly lower level than employees	• Continue to provide a safety net for all employees • Address affordability for lower paid employees via contributions that vary by salary and/or through employer account funding and through greater differentiation between plan options • Maintain commitment to employees and dependents, but limit coverage or charge more for coverage for spouses with other coverage

DRAFT GUIDING PRINCIPLES
CURRENT VS. DESIRED FUTURE STATE

Guiding Principles	Current State	Objectives/Future State
Employee Choice And Responsibility (Plan Design)	• Offer a choice of medical plans with modest differentiation in terms of plan design and minimal employee financial risk • No incentives for managing own health or choosing more effective providers	• Offer meaningful plan choices, including high deductible option(s) with significant employee accountability • Provide tools and employee-paid supplemental coverages to support individual employee decision making • Incent employees to manage their own health and choose effective providers
Program Management	• Offer basic care management programs through medical insurer aimed at helping sickest employees and their families • Offer the widest provider networks to support employee choice • Review budgets on an annual basis	• Offer evidence-based care management programs that serve the entire family • Offer wide provider networks, but encourage use of the most effective providers with a focus on “fee for value” vs. “fee for service” • Regularly evaluate program metrics
Culture Of Health	• No set vision or philosophy regarding employee health • Little reporting on health care drivers or impact of existing programs	• Create a culture of health with visible leadership support • Motivate employees to improve their health through a variety of evidence-based programs and incentives

SELF-FUNDING OVERVIEW - DEFINITIONS



SELF-FUNDING REVIEW - DEFINITIONS

DEFINITIONS OF COMMONLY USED TERMS ASSOCIATED WITH SELF-FUNDING

Aggregate Factor: The dollar figure that is multiplied by the number of covered persons each month during the contract period to calculate the Annual Aggregate Deductible (AAD).

Aggregate Stop Loss: Excess risk coverage that provides a ceiling on the dollar amount of eligible claim expenses that an employer would pay, in total, during a contract period. This is protection against abnormal frequency of claims in total rather than abnormal severity of a single claim.

Annual Aggregate Deductible: The number representing the overall limit ("ceiling") of claims liability for the group. Beyond this point, the stop loss policy indemnifies the group. Also called the trigger point or attachment point.

Claim Lag: The time between a claim's incurred date and its submission to the insurer for payment.

SELF-FUNDING REVIEW - DEFINITIONS

DEFINITIONS continued

Fiduciary: The person or entity who has management control and discretionary authority over the plan and its finances, design and administration.

Claim Reserves: Amounts set aside to ensure that funds are adequate for meeting incurred but not yet reported claims.

Expected Paid Claims: An estimate of the dollar value of claims to be paid during a contract period.

Fully Insured Plan: A Plan under which all risk is assumed by an insurance company. Claim payments are made with the insurer's money rather than the employer's money.

Self Insured Plan: A Plan under which all risk is assumed by the employer unless stop loss coverage is purchased to cover abnormal risks. The group does not purchase conventional insurance but rather elects to pay for claims directly.

SELF-FUNDING REVIEW - DEFINITIONS

DEFINITIONS continued

Specific Stop Loss: The form of excess risk coverage that provides protection for the employer against high claims on any one individual. This is protection against abnormal severity of a single claimant rather than abnormal frequency of claims in general.

Stop Loss Coverage: A category of coverage that provides insurance protection to an employer for a self-insured plan.

Terminal Liability: Financial responsibility for claims incurred but not reported. Generally, there is a payment date limit specified as to how long claims will be paid. This liability is only paid out when the self-insured arrangement is terminated.

Third Party Administrator (TPA): An independent company that administers group benefits, claims, and administration for an insurance company or self-insured employer.


MERCER
MAKE TOMORROW, TODAY