CONTRACTED REFERENCE BASED PRICING DISCUSSION

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State of Montana Employee Health Plan

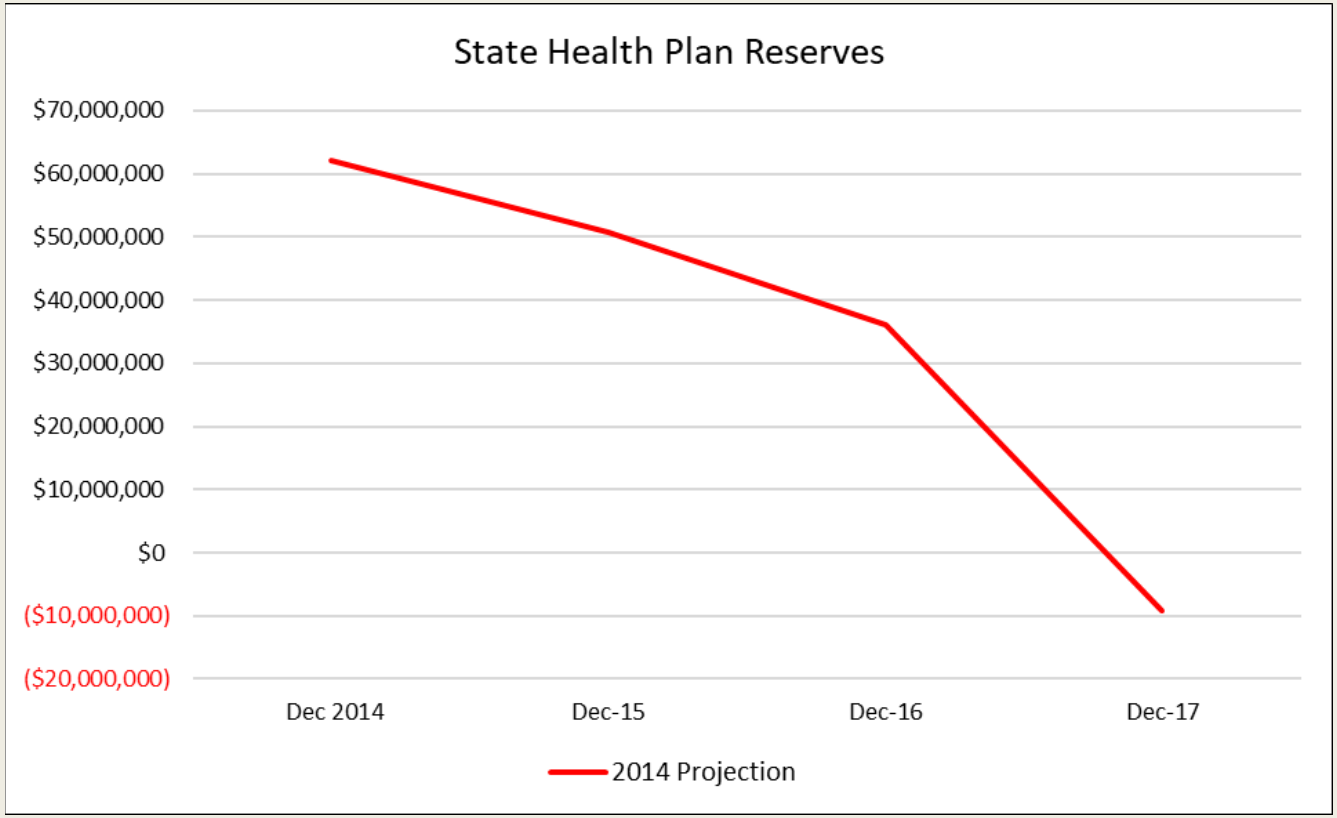
- 12,700 Employee Lives; 2,000 Retirees
- 31,000 Total Lives
- Self-Funded Plans for Medical, Dental, RX, Vision
- Largest Self-Funded Plan in Montana
- 5 On-site Employee Health Centers

Disclaimer: State Health Plan Administrator: Sep 2014 – Jun 2018

Not representing Office of the Commissioner of Securities and Insurance

Why did we take this path?

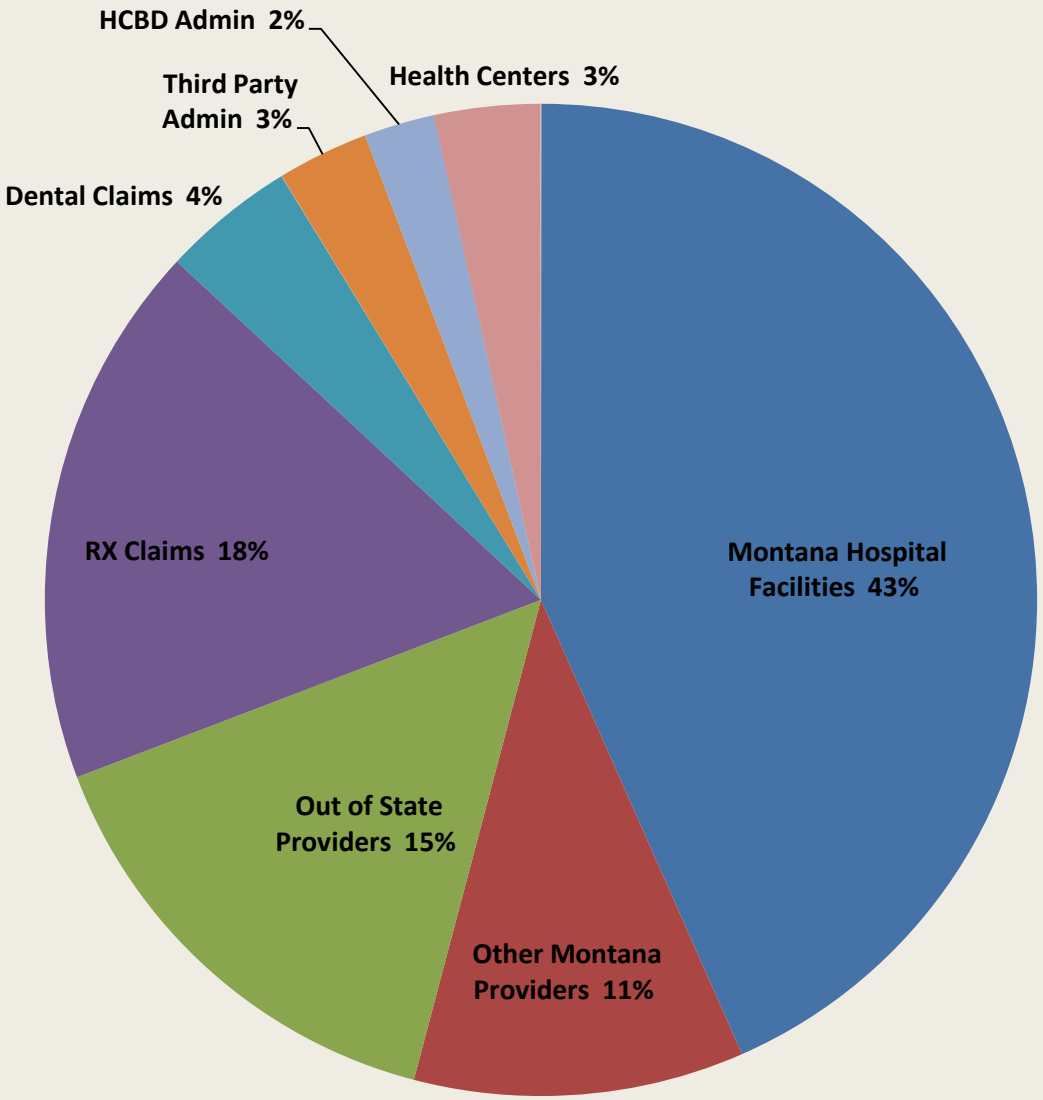
- Health Plan Condition
  - *Financial Condition of Plan – Late 2014*
  - *Montana Legislature – Senate Bill 418*
  - *Medical trend not sustainable*



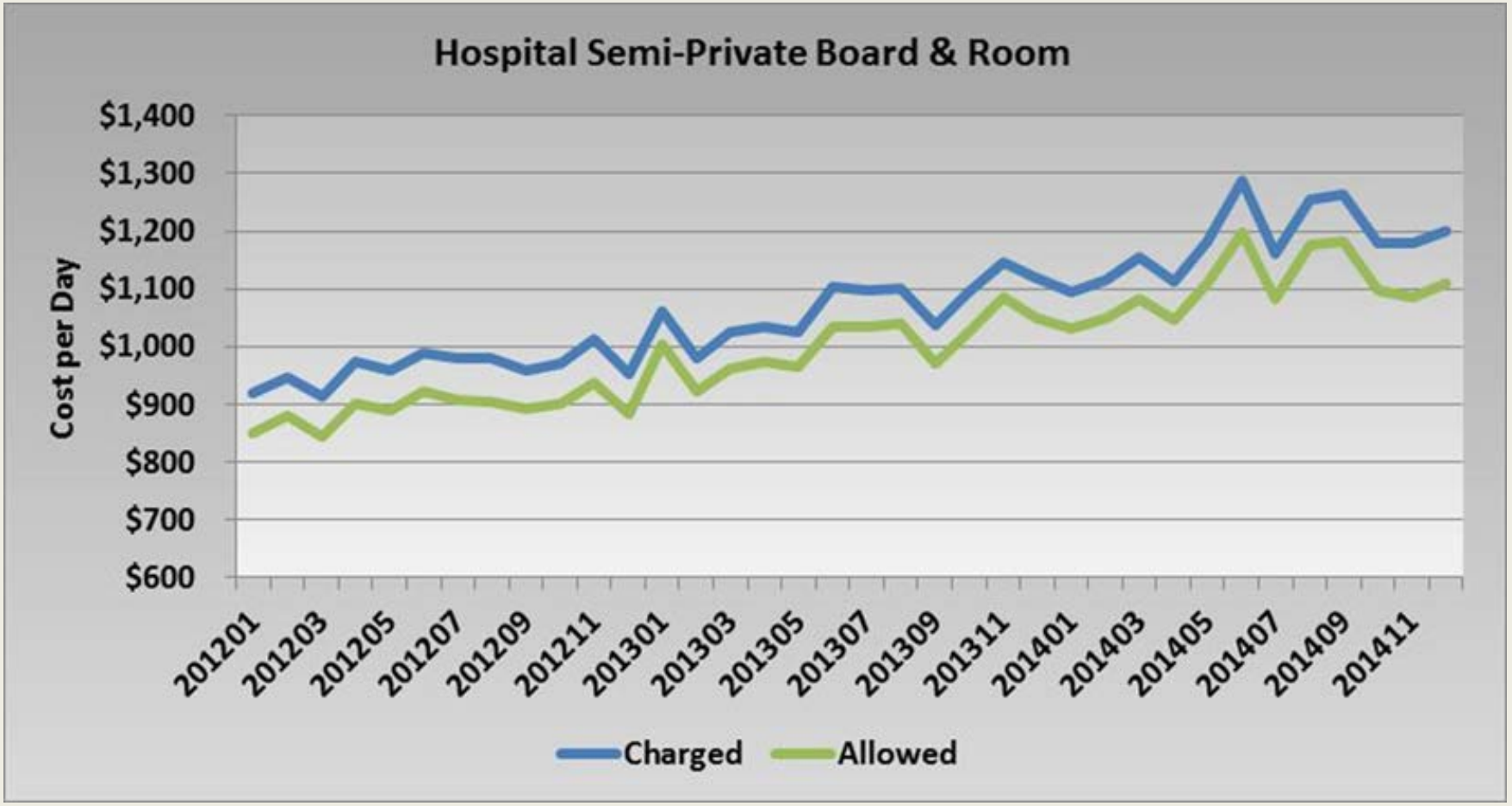
Why did we take this path?

- Initial obstacles
  - *Lack of strategy*
  - *Health Plan data not readily available*
  - *Contract Management not in place*
  - *Inefficient work flows and system processes*
- Concerned Stakeholders
  - *Vendors, Providers, Hospitals*
  - *Executive and Legislative Branches*
  - *Plan Members and Unions*
  - *Our own staff*

How are the plan costs distributed?



Will Discounts control rising costs?



Developing RFP Strategy

Goal = Montana Hospital Reimbursement will be a multiple of Medicare for ALL facility services

- Selected Medicare as reference point:
  - *Common reference to overcome variation in charge masters and differences in billing practices*
  - *Largest healthcare payer in country*
  - *Adjusted for case mix and geography*
  - *Calculation process publicly available*
  - *Moves Plan to DRG reimbursement methodology*
- State of Montana Plan "constraints":
  - *No Balance Billing = Contracting*
  - *No steerage or narrow network = Include all facilities, if possible*
  - *Needed quick financial results*
  - *Control over future reimbursement increases*
  - *State Procurement Regulations*

TPA Partner

- **Who would work with us to implement our RBP model?**
  - Current TPA not interested
  - June 2015 issued RFP. State Procurement laws do not allow direct contracting with facilities or providers.
  - 9 Respondents:
    - *3 said "NO"*
    - *1 offered standard network, but large claims paid outside network contracts at roughly 125% Medicare. Member would be balance billed, and TPA would legally fight balance billing.*
    - *1 offered standard network, stating the reimbursement levels "approximated 250% Medicare", but reimbursement would remain charge less discount*
    - *3 offered narrow network*
    - **1 said "we will work with you, and we have already begun data analysis", and we forged a partnership!**

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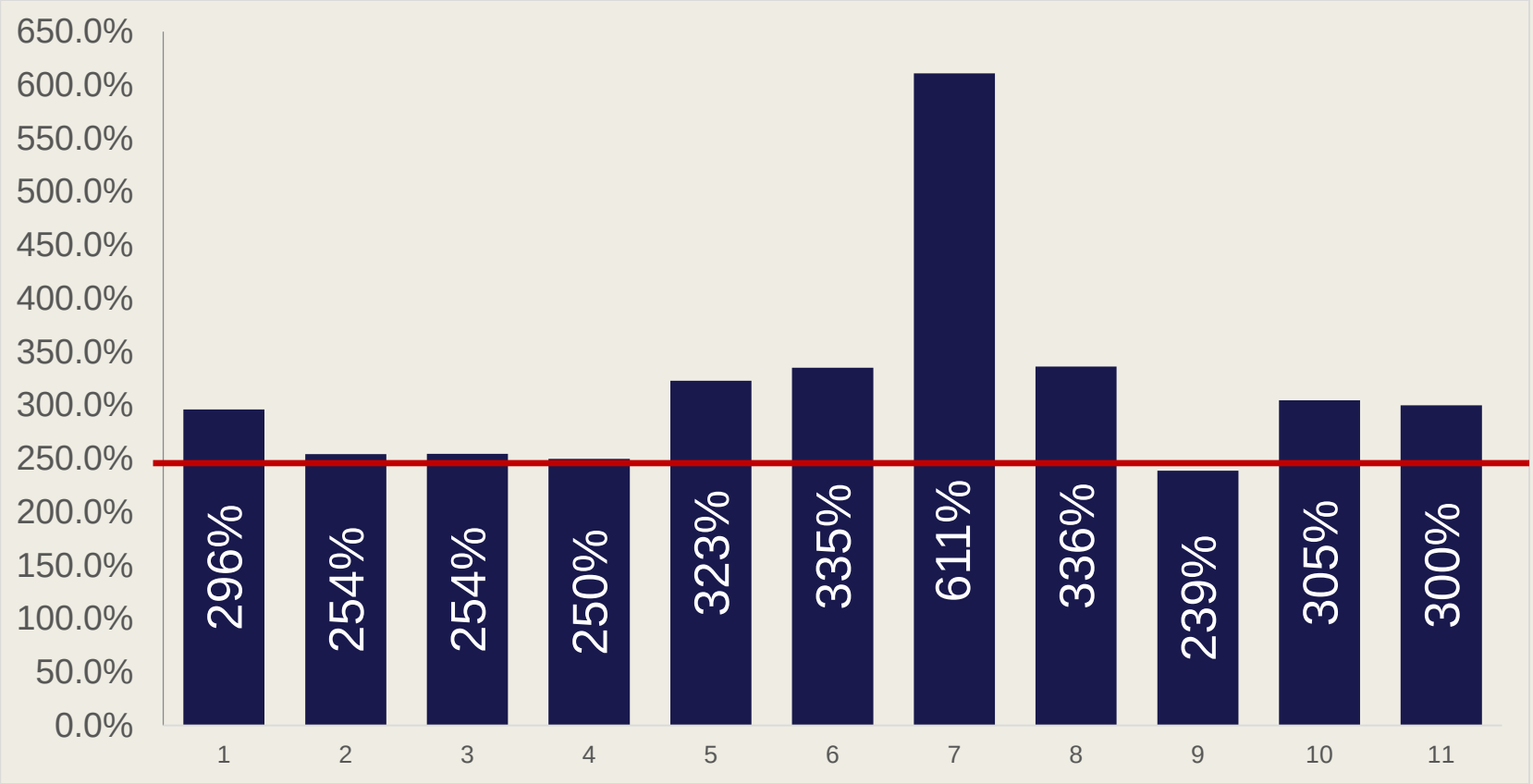
Outpatient Cost Comparison



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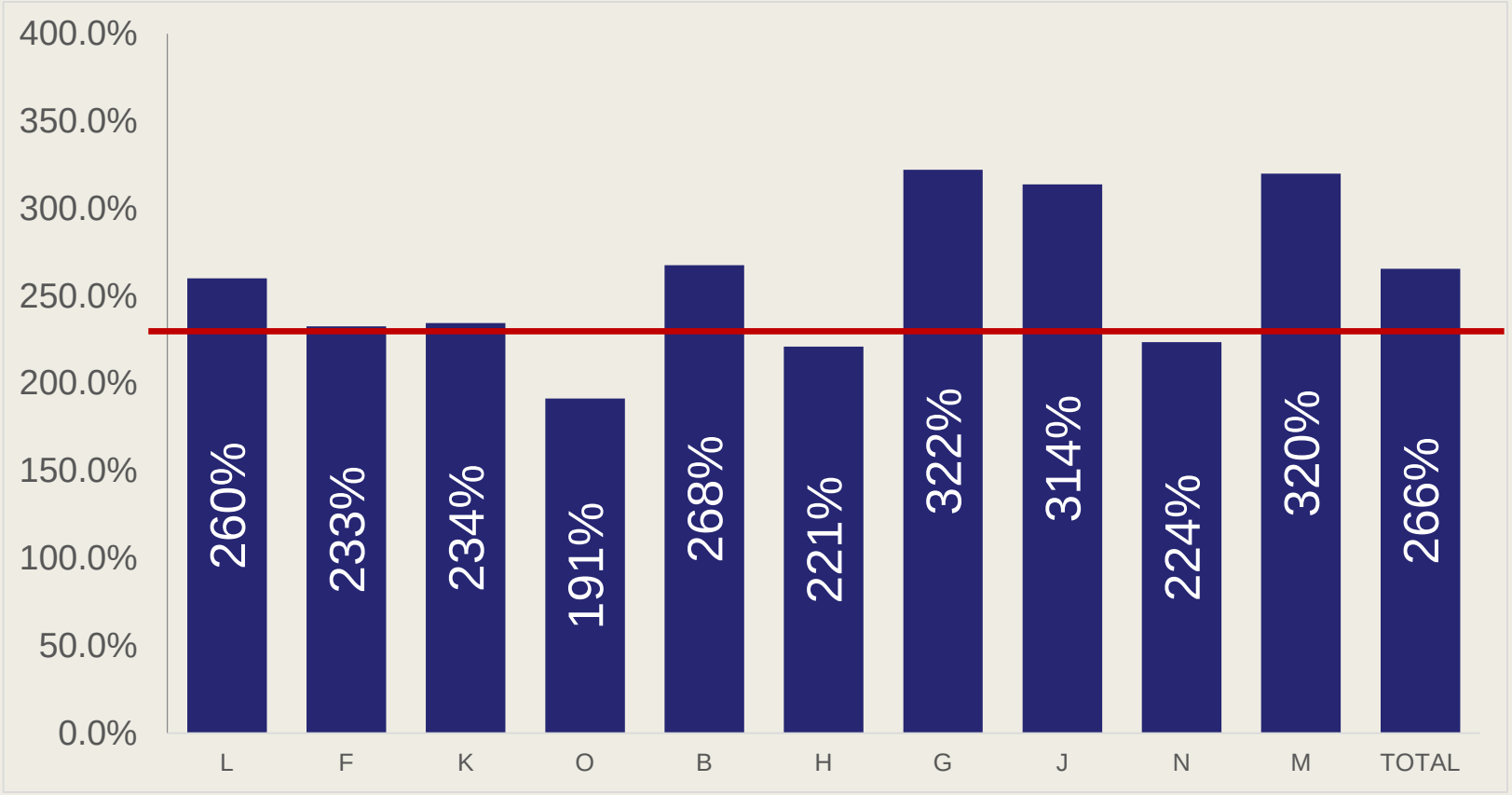
Inpatient Cost Comparison



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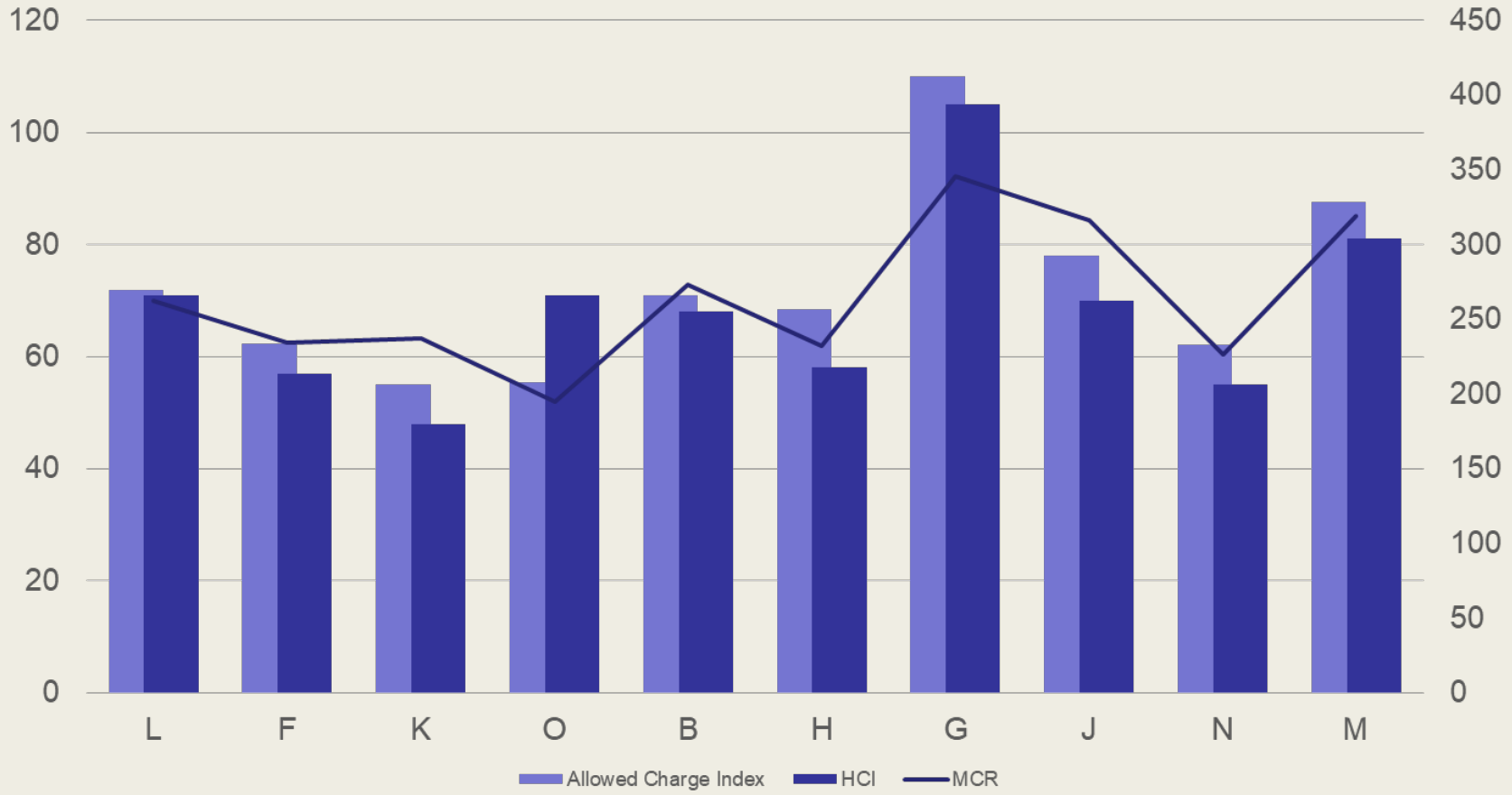
Cleaverly & Associates



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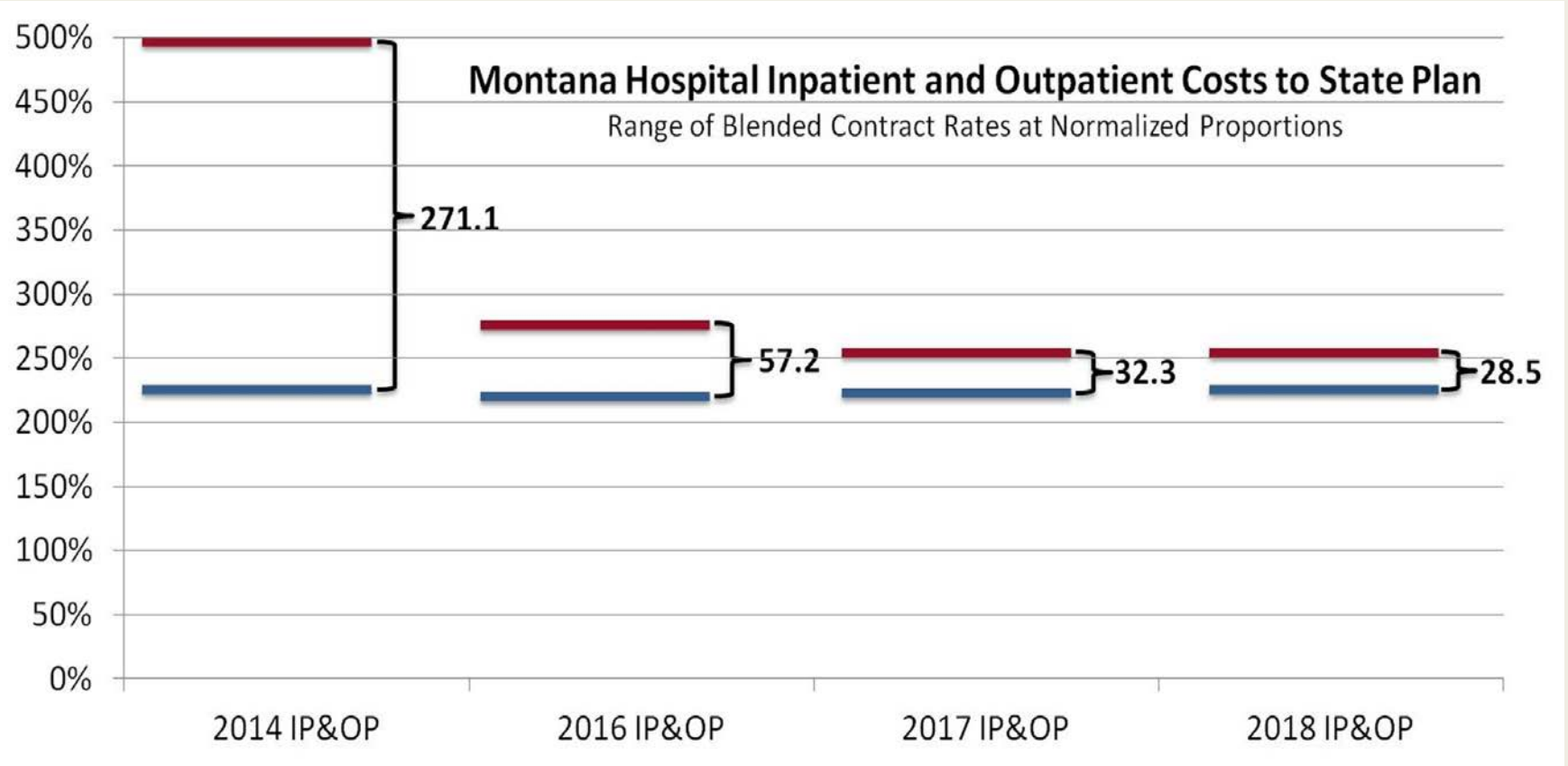
Contracted Reference Based Pricing



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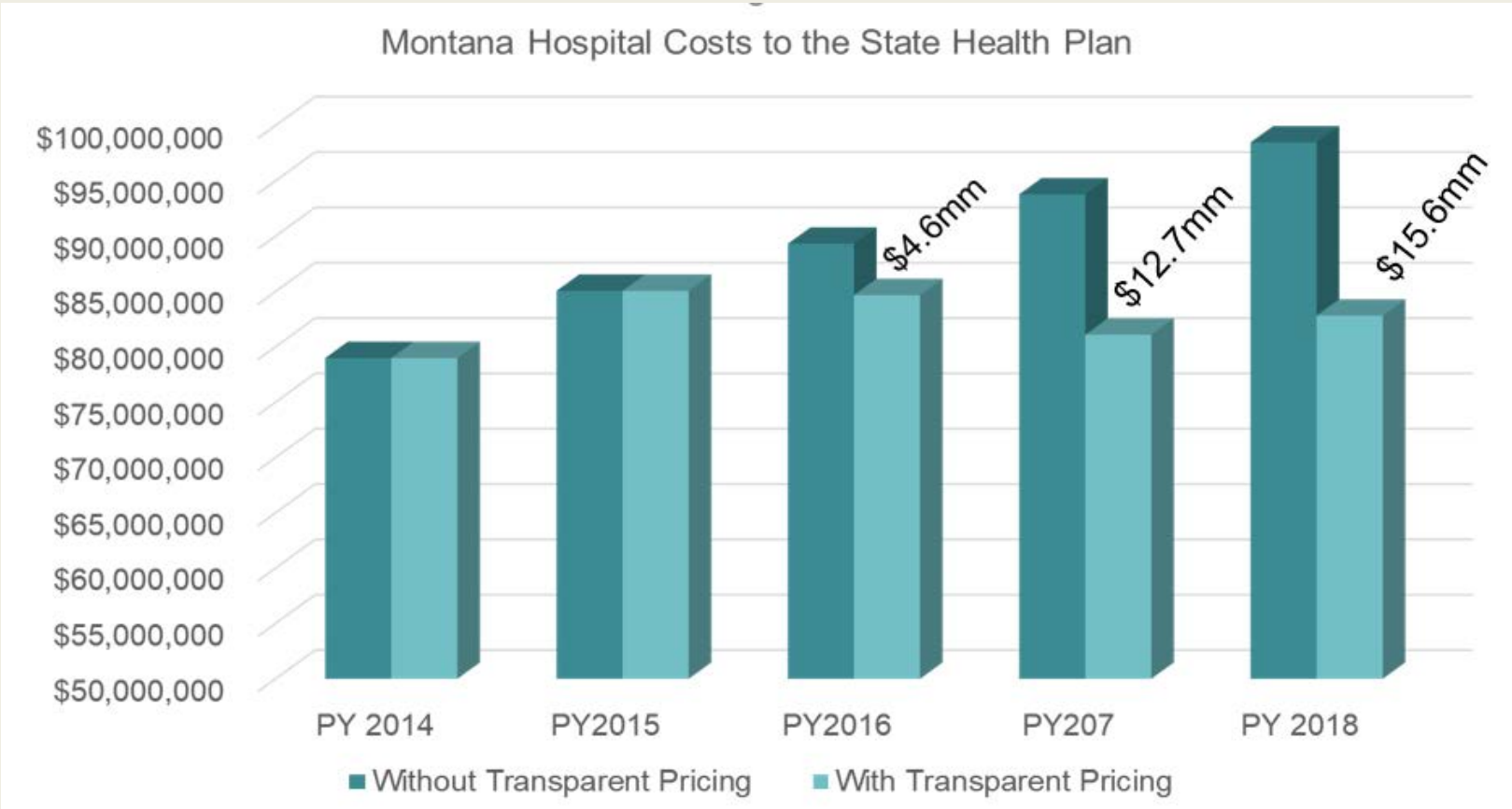
Contracted Reference Based Pricing Projection



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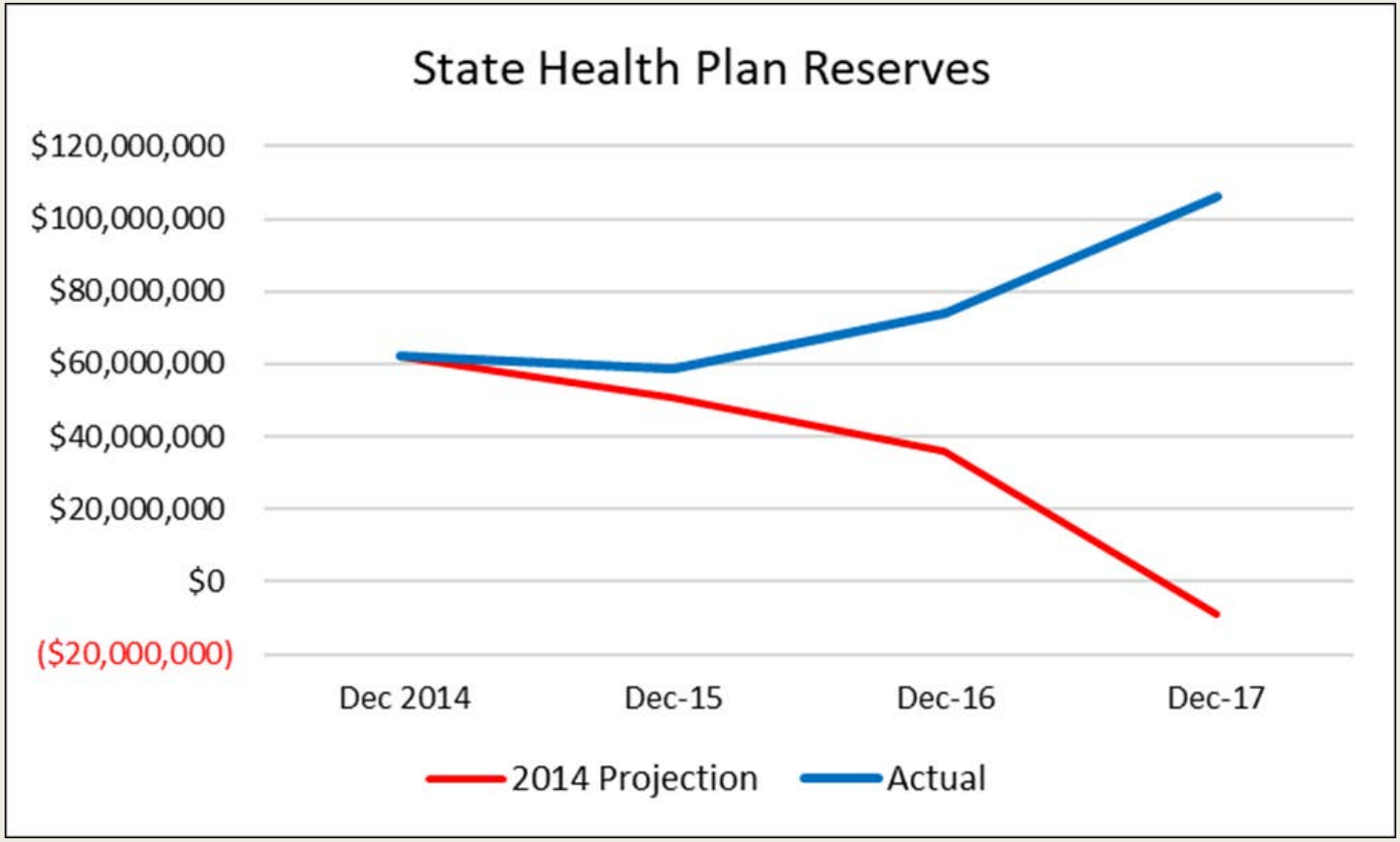
What else did we do?

- Transparent, pass-through pharmacy benefit = $7.4 million savings
- Added EGWP RX benefit for retires = $2.8 million savings
- Terminated duplicate wellness vendor contracts = $5.5 million savings
- 24% reduction in TPA administrative fees = $850,000 savings
- 18% reduction in onsite clinic administrative fees = $400,000 savings
- Moved from ERP to cloud based Benefit Enrollment and Administration system = $1.5 million savings
- 23% staffing reduction = $200,000 savings
- Moved to cloud based Data Warehouse = $500,000 savings

So what happened in December 2017?



What is Next?

- Montana
- Colorado
- North Carolina
- Indiana
- Nevada
- US Senate HELP Committee
- National Association of Insurance Commissioners (NAIC)

Questions?