Approved 9/24/2015

State Employees Health Plan Task Force
Wednesday, September 9, 2015
Haslet Armory, Dover, Delaware 19901

The State Employees Health Plan Task Force Committee met on September 9, 2015, at the Haslet Armory Building, Conference Room 219 in Dover, Delaware. The following Committee members and guests were present:

Ann Visalli, Director, OMB
Brenda Lakeman, Director, OMB, SBO
Faith Rentz, Deputy Director, OMB, SBO
Lisa Porter, OMB, SBO
Tim Barchak, NEA
Laura Beck, AOA
Michael Begatto, AFSCME
Dave Chisholm, Willis
Heather Contant, Leg Hall (for Sen. Dave Lawson)
David Craik, Pension Office
Kristin Dwyer, DSEA
Jim DiGuiseppe, Willis
James Dawson, WDDE
Jessica Eisenbrey, OMB
Patty Friedman, Aon Hewitt Consulting
Debra Gerardi, OMB
Pat Griffin, AOC
Darcell Griffith, Univ of DE
Kim Hawkins, City of Dover
Andrew Kerber, DOJ
Geoff Klopp, COAP
Omar Masood, OST
Brian Maxwell, OMB
Sen. Harris McDowell, Leg Hall
Larry Mitchell
Mike Morfe, Aon Hewitt Consulting
Jennifer Mossman, Highmark DE
Evelyn Nestlerode, AOC
Bill Oberle, DSTA
Pam Price, Highmark DE
Kimberly Reinagel-Nietubiez, CGO
Paula Roy, Roy Associates
Roger Roy, Teledoc
Ken Simpler, OST
Wayne Smith, DHA
Jeff Taschner, DSEA
Chris Ulrich, Univ of DE
Jennifer Vaughn, DOI

Introductions/Sign In
Director Visalli called the meeting to order at 10:08 a.m. Everyone was reminded to sign in. Introductions were given around the room.

Due to the limited time and the task set forth for this committee, there will not be time allotted for public comments. A Health plan task force email and website has been created. In addition if people prefer to submit comments, there are four scheduled workshops in September for Public Testimony.

Mr. Begatto requested a list of those attending this meeting that are not part of the committee.

Senator McDowell expressed opening comments one of which should be a complete post-mortem of what occurred that resulted an unexpected $70M over run in costs whether it was a series of events or on-going trend. This will help decide what needs to be next.

Director Visalli stated this meeting is more of an overview of understanding the existing plan designs and current state, sizing the problem and addressing the issues. The next meeting on September 24th will focus more in depth with Truven on the analytical detail. Aon Hewitt Consulting will facilitate discussion in this meeting.

Mr. Begatto asked how long Truven has been under contract with the State of Delaware. Director Visalli responded that Truven has been under contract since 2006. Mr. Begatto also asked if there has been any consideration of an audit on the prescription drug and medical plans. Director Visalli responded that this is all covered under the epilogue and this will be covered by this committee to recommend this if determined to be needed.

Mr. Oberle inquired on the cost drivers and asked if we are able to look at Medicaid reimbursement rates to healthcare providers versus actual charges the State has incurred. Director Visalli responded that there are Medicaid allowable reimbursements rates and then there are rates paid in the health plan and what those differences are is something that could be included in a future agenda.

Mr. Begatto asked about Aon's role. Director Visalli stated that within the epilogue of Section 73 it states the Office of Management and Budget (OMB) shall engage a consultant to conduct an operational review from an actuarial and benefits perspective.

Senator McDowell requested trends in the private market. Director Visalli informed that the Insurance Commissioner will have this information.

Senator McDowell asked what would happen if the State were fully insured by an insurance carrier and the plan experienced a $70M loss, how would the insurance carrier recover from such a loss as it appears that the State as a self-insured plan is forced to make up for such a loss immediately. Director Visalli responded that as the State is self-insured, we absorb the cost directly through the State's health fund. If we had fully insured healthcare coverage, premiums would be set for each plan year and if the State experienced this spike in claim costs, our premiums in subsequent plan years would be much higher to purchase the same health insurance. This is something to discuss.

Mr. Oberle added to consider a look at the Medicaid reimbursement rates from healthcare providers and then see what the State is being charged. His research on Worker's Compensation reform suggested in some instances that commercial plans were paying 600% higher than Medicaid. These charges are worth discussing.

Mr. Taschner asked per the Epilogue if DSEA can continue to work with Milliman along with Aon on board. This is fine per Director Visalli.

Mike Morfe, Aon Hewitt Consulting steered the committee to the Plan Overview in the presentation that shows the Group Health Insurance Program (GHIP) is available to 73% active employees, 8% non-Medicare (NM) retirees and 19% Medicare Primary (MP) Retirees with 67,000 contracts and just over 122,000 covered lives. Mr. Taschner commented that the CDH plan started in 2012 where the other plans go back further. Mr. Begatto asked for actual numbers versus percentages including the non-participating groups.

There are six active/non-Medicare plans and one Medicare supplement plan. All plans include prescription drug coverage. The percentage of what the State pays and what the member pays for each plan were provided. Senator McDowell stated we could reduce costs by pushing people to engage in preventive care and wanted to know the State's progress in having members meet preventive care goals. Director Visalli reminded the committee that effective July 1, 2015, there are no State co-pays for preventive care and more broadly, we are hoping to discuss those items that drive down costs like wellness participation. Mr. Oberle requested a more thorough understanding of how the PBM, Express Scripts works and what benefits the State derives and as mentioned, maybe an audit is appropriate.

GHIP is self-insured for health and prescription benefits. Approximately 95% of total contributions are used to pay claims. Premiums are the same for actives/Non-Medicare retirees. The concept of actuarial value was reviewed and a chart showing the State plans versus some sample marketplace Platinum and Gold Plans. The State Employee Benefits Committee (SEBC) regularly reviews GHIP costs and interested parties convened in 2011 resulting in House Bill 81 to address Health and Pension reform. GHIP health benefit premium increases represented the largest addition to the State general fund budget in FY16. The State pays 91.4% of total health premium on average. Projected trend is 7.1% annually based on the last three years of actual GHIP costs.

Sources of cost increases are driven by both medical and prescription components including the number of services and medications show higher utilization and severity of the diagnosis / treatment protocol. Medical costs are beginning to

increase from historically low levels. Pharmacy costs have increased significantly and Aon now expects trends through 2017 to be 5.5% for medical and 10.5% for prescription drugs. Forecasting State Group Health costs puts projected expenses at over $1B by 2020. Cost increases cannot be absorbed through premiums alone.

Areas to address the deficit may include plan design, rate setting process, rates across plans, premiums based on income, cost share of premiums, increased participation in wellness programs, surcharges based on wellness activities, deductibles, high cost claims, case management, third party administrators and prescription benefits manager. Other areas to address the deficit include centers of excellence, employee health centers, consolidation of plans, covered groups and eligibility of members , coordination of benefits, double state share, disease management and wellness outcome measures, alternate coverage and the Cadillac Tax/excise tax.

The path forward includes a blueprint for solving the next several years' projected deficit. The Task Force charter is to submit the recommendations to the Governor and General Assembly no later than December 1, 2015.

The next steps are to determine if a dollar amount should be targeted, to determine the time period to achieve savings, to determine the scope of populations to assess changes for medical and prescription drug benefits and to determine options to find cost savings and efficiencies. A reminder that SEBC approval is needed and some legislation may be required.

Solving the Deficit – two dimensional staging of options were presented.

The next Task Force meeting is scheduled for September 24, 2015 at 10:00am in Buena Vista, Buck Library in New Castle. The meeting was adjourned at 12:13 p.m.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office, OMB