State Employees Health Plan Task Force Public Testimony Meeting

December 2, 2015

Introduction

- Welcome
- Epilogue Language in FY2016 Budget (Section 73) created State Employees Health Plan Task Force
- Members:
  - Chair – Director, Office of Management and Budget (also Chair of State Employee Benefits Committee (SEBC)
  - Other members of SEBC (or their designees)
    - State Treasurer
    - Insurance Commissioner
    - Controller General
    - Chief Justice of the Supreme Court
    - Representative of the Correctional Officers Association
  - Representative of AFSCME
  - Representative of Delaware State Troopers Association
  - Representative of Delaware State Education Association
  - Legislators
    - Co-Chairs of the Joint Finance Committee (JFC)
    - Two representatives of minority caucus also members of JFC

Introduction

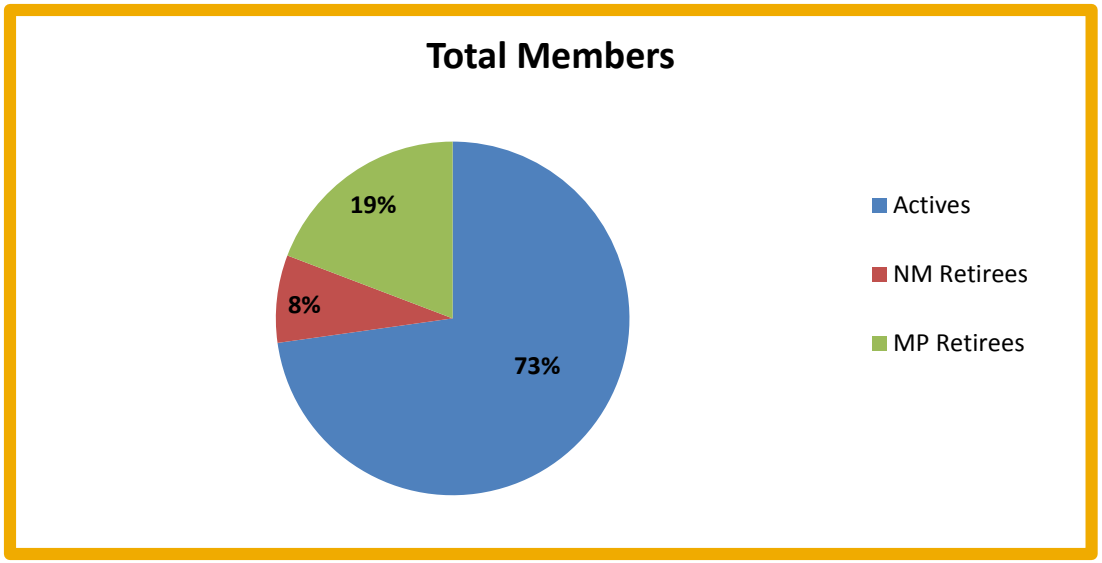
- Purpose: finding cost savings and efficiencies
- Areas of Inquiry: plan design, rate setting process, rates across plans, premiums based on income, cost share of premiums; increased participation in wellness programs, surcharges based on wellness activities, deductibles, high cost claims, case management, third party administrators, prescription benefits manager, 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, and alternate coverage (market place, exchange and insured), and the Cadillac Tax (excise tax)
- The Task Force met bi-weekly from September 9 through November 17th with last meeting to be held tomorrow, December 3, 2015
- Purpose of this meeting:
  - Receive public comment on subject of State Employees Health Plan
- Task Force date to provide report to the legislature extended to December 15, 2015

Public Comment

- General process for public comment
  - During public testimony meetings
    - Individuals are allotted 3 minutes
    - Individuals representing an organization are allotted 5 minutes
  - Suggestions mailbox – healthplan.taskforce@state.de.us

Group Health Insurance Plan Overview

- The Group Health Insurance Program (“GHIP”) is available to:
  - Active Employees,
  - Non Medicare (NM) Retirees
  - Medicare Primary (MP) Retirees
- The above groups represent 67,000 contracts and just over 122,000 covered lives



Based on GHIP financial reporting through FY15
Includes NonState group membership – 7,300 contracts/17,100 members

Plan Overview – Understanding the GHIP Health Plans

- Health Plan Options Available to GHIP members
  - 6 active/non Medicare plans (same plans available to both groups)
  - 1 Medicare supplement plan (supplements coverage and services not covered by traditional Medicare)
  - All plans include prescription drug coverage administered by Express Scripts

	Actives	Non Medicare	Medicare Primary
Premium Cost Share Percentage Split	**State/Employee**	**State/Retiree**	**State/Retiree**
Highmark Comprehensive PPO	86.75%/13.25%	86.75%/13.25%	
Highmark & Aetna HMO	93.5%/6.5%	93.5%/6.5%	
Highmark & Aetna Consumer Directed	95.0%/5.0%	95.0%/5.0%	
Highmark First State Basic	96.0%/4.0%	96.0%.4.0%	
Highmark Special Medicfill Supplement			100%/0%* 95.0%/5.0%**

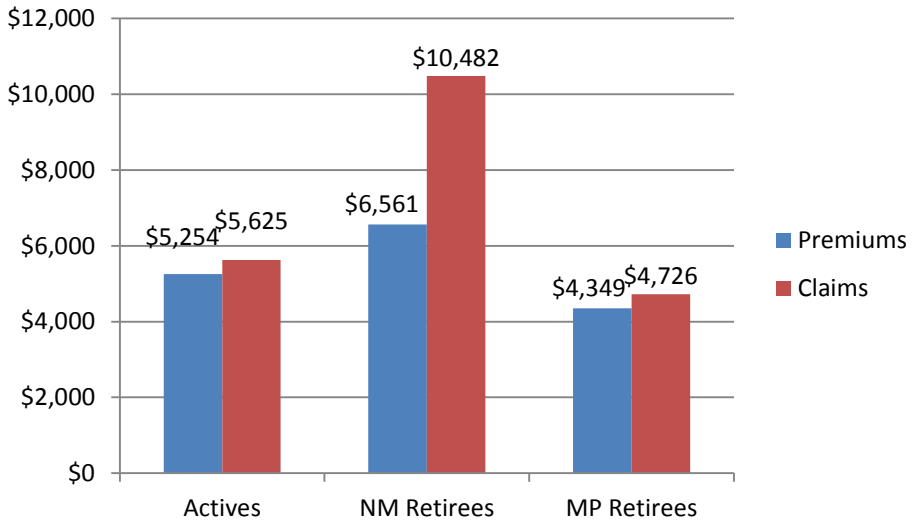
*Retirees with full state share who retired before July 1, 2012

**Retirees with full state share who retired after July 1, 2012

Plan Overview – Understanding the GHIP Health Plan Premiums

- GHIP is self-insured for health and prescription benefits
  - Health plan premiums paid to GHIP are used to pay:
    - Actual claims incurred by GHIP members
      - Approximately 95% of total contributions are used to pay claims
    - Administrative fees to Highmark, Aetna and Express Scripts
    - Premiums are the same for actives/Non Medicare retirees
    - Per capita claims for active members are significantly less than Non Medicare Retiree members

Per Capita Claims vs. Per Capita Premiums*



Prepared by Aon
Consulting | Health & Benefits

***Based on GHIP financial reporting through FY15**

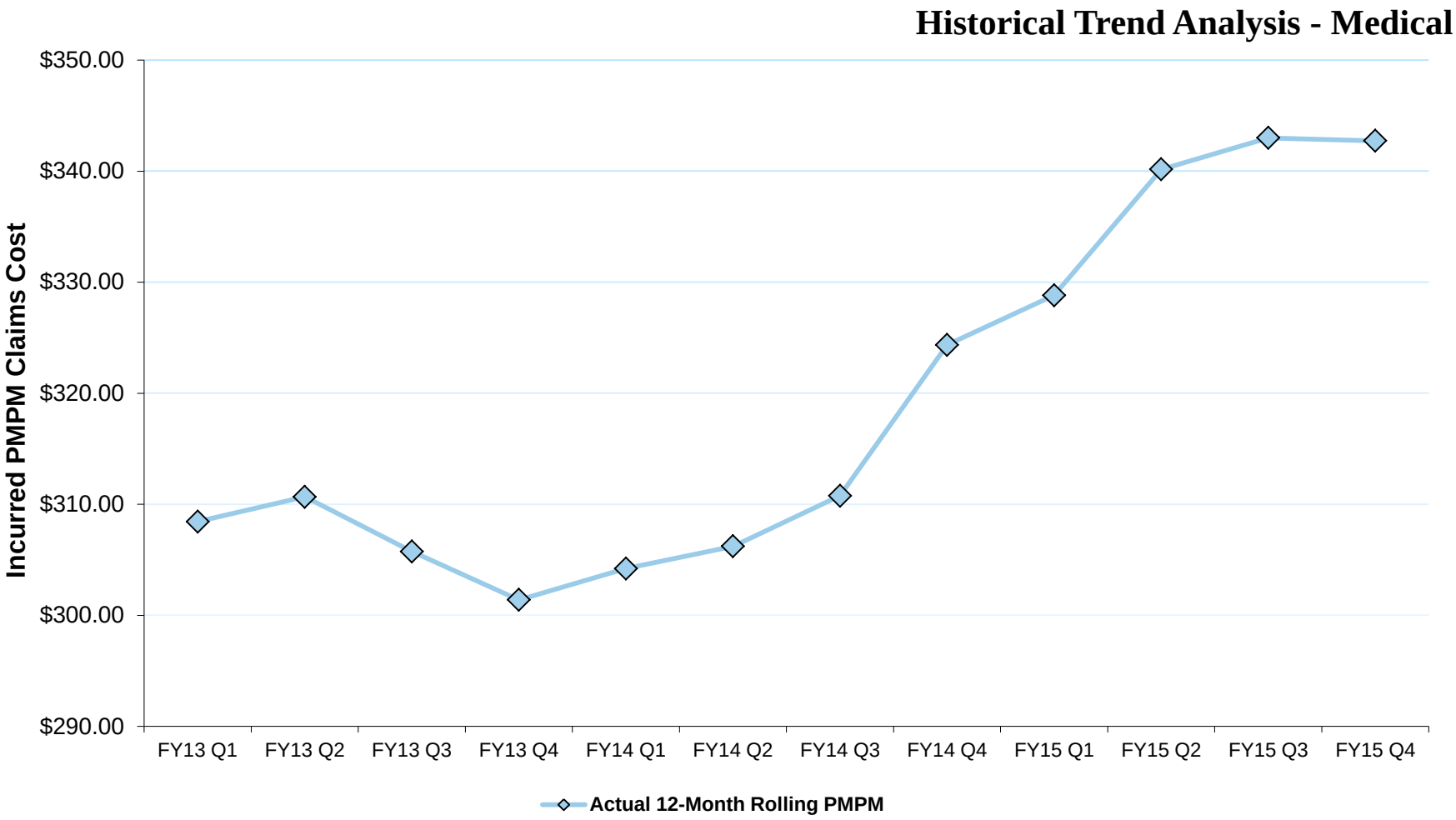
Historical Overview of GHIP Costs

- The State Employee Benefits Committee 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 State general fund budget in FY16 - $47.1M
  - State pays 91.4% of total health premium on average
  - Employee/Non Medicare eligible pensioners pay 8.6% of total health premium on average.
    - Employee/Non Medicare eligible pensioner premiums increased $3.86 to $37.46 per month effective September 1, 2015
- Challenge of managing health premium increases needed to fund rising costs accelerated in FY14
  - If costs continue to increase at rate experienced in most recent year, GHIP costs will exceed $1 billion by FY2020

High Level Cost Increase Overview

- Sources of cost increases are driven by both medical and prescription components.
  - Number of services and medications = Higher utilization
  - Severity of the diagnosis/treatment protocol
- On the medical side:
  - Outpatient surgery
  - Inpatient hospital admissions
- On the prescription side:
  - Rising cost of brand and specialty drugs,
  - Slowdown of drugs going generic,
  - Generic costs leveling off, and
  - New costly specialty drugs including the new Hepatitis C treatments.

GHIP Medical Costs Per Member Per Month



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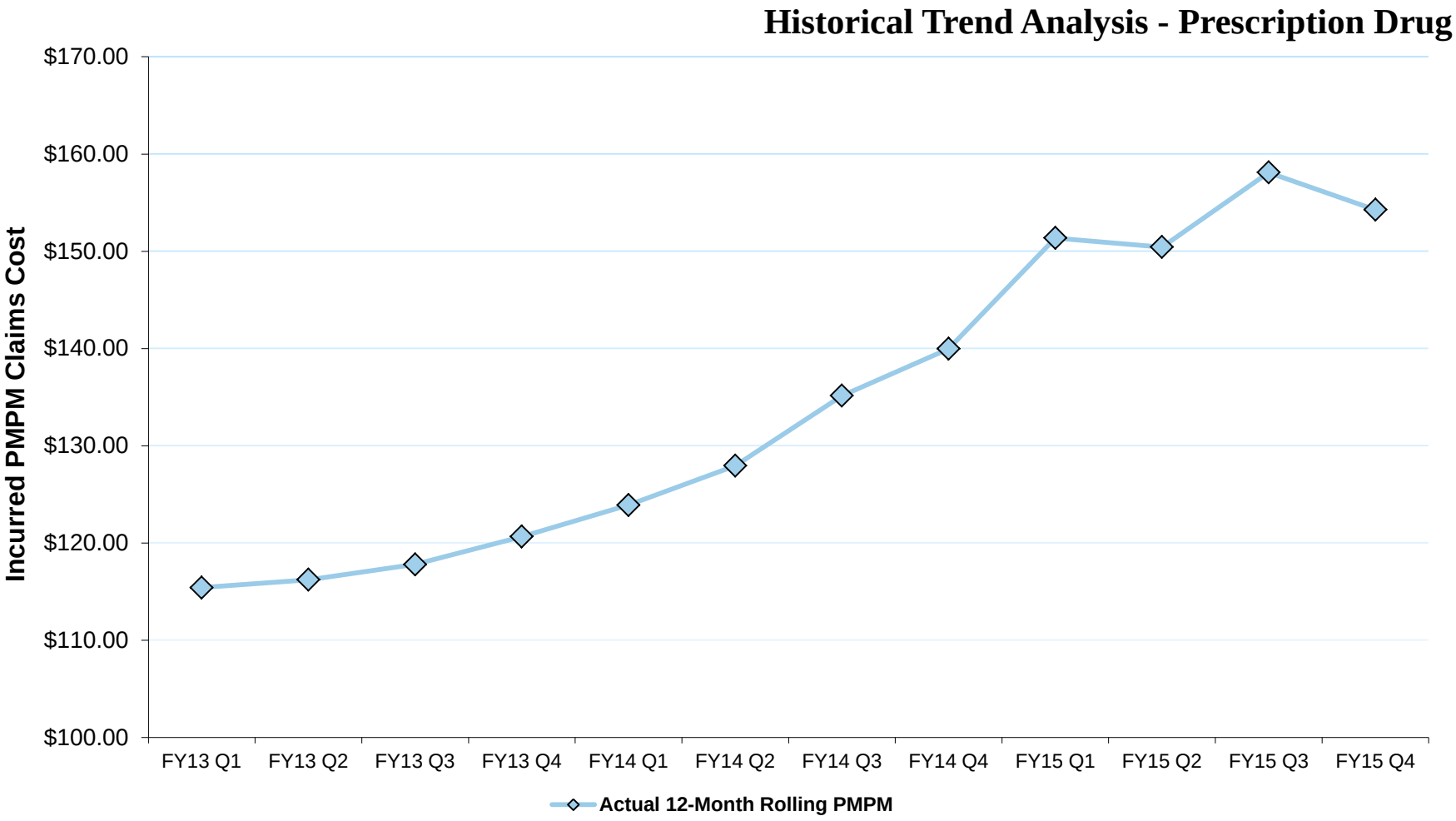
GHIP claim data -Chart prepared by Segal

GHIP Prescription Drug Costs Per Member Per Month



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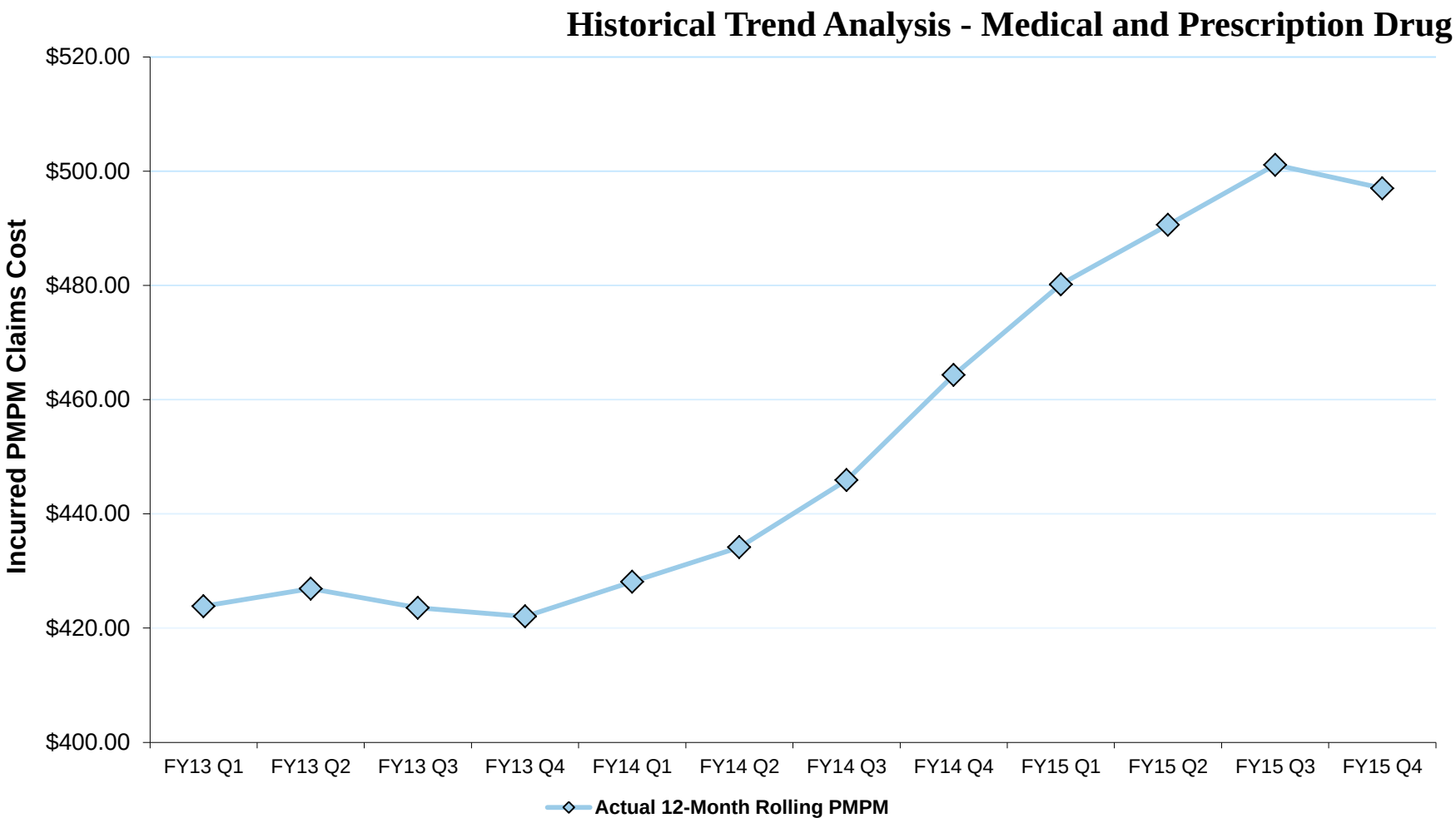
GHIP claim data - Chart prepared by Segal

GHIP Medical and Prescription Drug Costs Per Member Per Month



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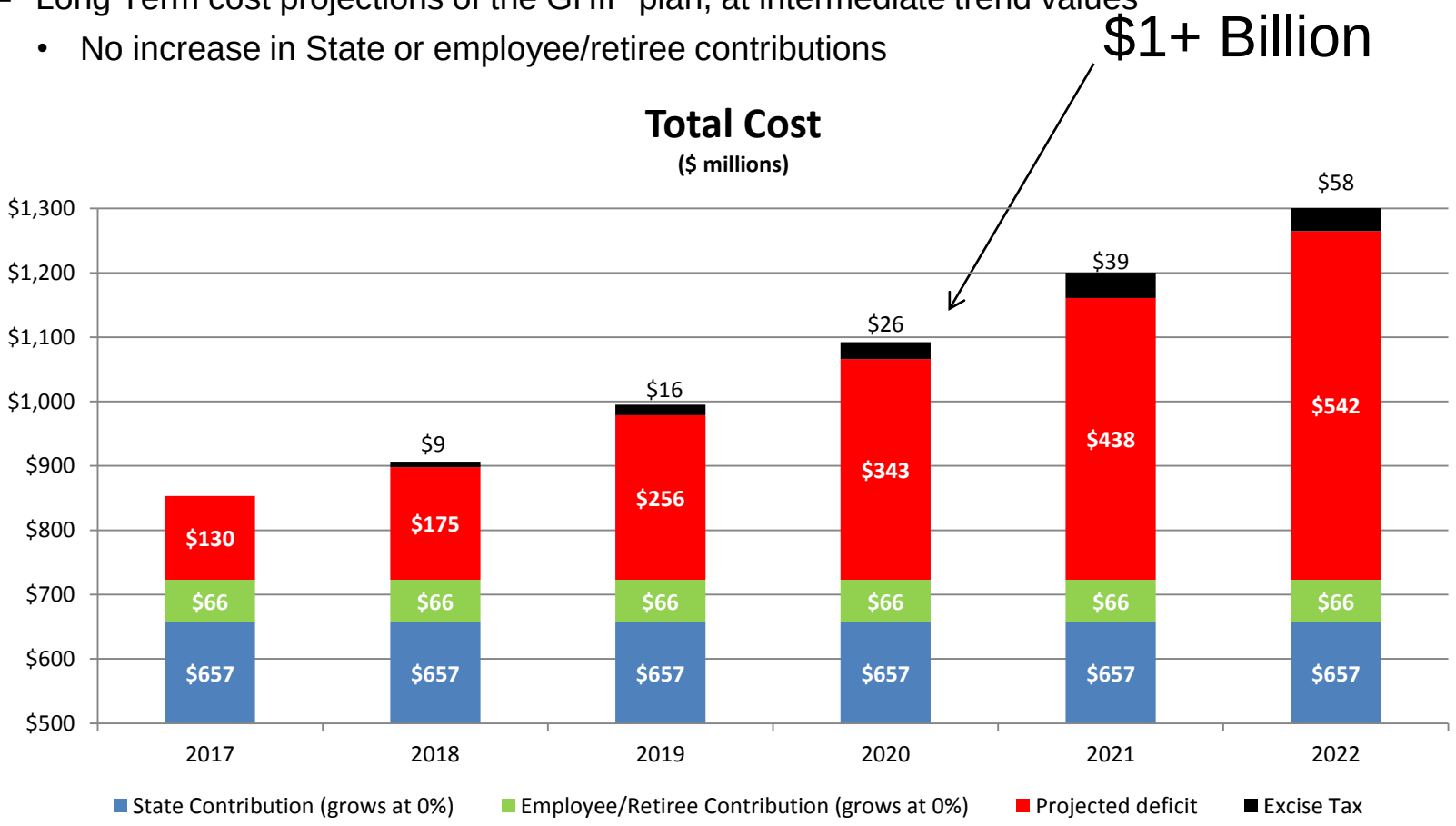
GHIP claim data- Chart prepared by Segal

Medical and Prescription Drug Trend – overview of current market

- Medical costs are beginning to increase from historically low levels.
- National surveys show trend (increase in plan costs year over year) is expected to be 5.5% for medical, and 10.5% for prescription drugs, which is approximately 7% overall.

Sizing the Problem- Long Term Projections

– Long Term cost projections of the GHIP plan, at intermediate trend values
  • No increase in State or employee/retiree contributions



Data from various Segal documents, long term projections at 9% trend.

Areas to Address the Deficit – Finding Cost Savings and Efficiencies

- 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
- Prescription benefits manager
- 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 (market place, exchange and insured), and
- The Cadillac Tax/Excise tax

Redesign plans/ Plan Design

- Plan Design 1 - Two Consumer Directed Health plans (CDHP)– Only plans offered
  - High and Low Option
    - High Option current CHDP design with Health Reimbursement Account
      - Higher premium, lower out-of-pocket
    - Low Option CDHP with Health Savings Account
      - Lower premium, higher out-of-pocket
- Plan Design 2 - Two Option “gated” plan design -- Only plans offered
  - High and Low Option similar to above
  - High Option only available if key health management / biometric tasks performed (the “gate”)
- Plan Design 3 - Managed Care (HMO) Plans – Only plans offered
  - PCP required to focus on care coordination and pay for value
- Plan Design 4 - Keep all current plans with change in plan design with increase in cost-sharing with employees
- Plan Design 5 - Active Exchange (private) – group basis
  - Use private exchange with group programs, offer silver (70% AV), gold (80% AV), platinum (90% AV) plan
  - Plan design is determined by plan sponsor, from offering of available plans on Exchange

Premium / Cost-Sharing Structure

- Increase contribution percentages –
  - Currently 4% for FSB, 5% for CDHP, 6.5% for HMOs, and 13.25% for Comp PPO
  - Increase contribution percentages consistently across plans
- Institute Buy-Up structure – similar to structure prior to 2012
  - One lowest cost option
  - All other plans require employee to pay the premium difference between lowest cost plan and higher cost plan
- Implement salary-based contributions
- Subsidize dependents different than employees – State would pay less of the additional cost to cover spouse and/or dependent children
- Eliminate “Double State Share”
- Implement surcharges
  - Tobacco
  - Wellness Assessment / Health Screenings / Health Risk Assessment
  - Working Spouse

Health Plan Management

- Value-Based Design: Target highest cost/risk chronic conditions & provide financial incentives/cost share reduction
- Implement reference based pricing for certain procedures such as outpatient diagnostic testing and/or elective procedures
- Implement Tiered Networks on Lab: copay lower for outpatient lab services obtained at a freestanding lab versus hospital based lab services
- Pre-Authorize high tech radiology and direct care to lowest cost freestanding facilities(sites of care)
- Provide onsite services: Primary Care, Urgent Care, Physical Therapy
- Centers of Excellence: Steer patients with financial incentives to centers of distinction based on quality/outcomes and cost

Retiree Options

- Plan Design Changes - Separate Non Medicare Retiree plan from Active Plan
- Utilize Non-Medicare Retiree Exchange
- Utilize Medicare Retiree Exchange
- Establish Medicare Advantage Plan – National in nature, PPO plan design
- Maintain State Medicare Primary Medical Plan with plan design changes with increased cost share for Medicare retirees

Payment Reform – Different Methods to Pay Providers

Current Payment Methods:

- Historically hospitals paid on a percent of billed charges
- Some hospitals still paid all or in part on a percent of billed charges
- Some hospitals have agreed to payment based on Diagnostic Related Group, such as set amount for knee replacement surgery
- Other providers paid on allowable charge established contractually which is lower than billed charge and

Possible New Payment Methods:

- Increase Pay for Value (P4V) initiatives in State, with providers
- Implement Regulatory Authority (rate setting)
- Implement Risk-Based contracts – Gain Sharing or Loss dependent upon performance
- Implement Increased Number of Payments based on Diagnostic Group, i.e. Knee Replacement
- Implement Fee Maximum payment schedule (% of Medicare or Medicaid)
- Direct Provider Contracting

Prescription Drug Specific Changes

- Active and Non-Medicare Retiree coverage changes discussed
  - Increase drug utilization management – stricter guidelines for certain medications to be covered by State
  - Moving coverage of certain medications now paid for by medical plan to payment by prescription plan in order to obtain medications at lower cost

- Medicare Retiree Drug coverage changes discussed
  - Remove coverage for drugs not covered under a Medicare Part plan
  - Move drugs covered by prescription plan that could be covered under Medicare Part B by the federal government

Public Comment