

State Employee Benefits Committee
Tatnall Building, Room 112
Dover, Delaware 19904

Approved 4/10/2017

The State Employee Benefits Committee met March 24, 2017. The following people were in attendance:

Committee Members:

Mike Jackson, Director, OMB
Rick Geisenberger, Secretary of Finance
Molly Magarik, Designee of DHSS Secretary
Mike Morton, Controller General
Trinidad Navarro, Insurance Commissioner
Evelyn Nestlerode, Designee of Chief Justice, Administrator of Courts
Ken Simpler, Treasurer
Keith Warren, Designee of the Lt. Governor

Guests:

Brenda Lakeman, Director, SBO
Faith Rentz, Deputy Director, SBO
Lisa Porter, SBO
Joanna Adams, Pension Office
Deloris Hayes-Arrington, Finance
Jennifer Bredemeier, Univ of DE
Lisa Carmean, City of Milford
Patricia Davis, DOJ
Jacqueline Faulcon, DRSPA
Karin Faulhaber, PHRST
Judy Grant, HMS

Guests (continued):

Leighann Hinkle, SBO
Chris Hudson, OMB
Margaret Merkley, DRSPA
Brad Messinger, WTW
Regina Mitchell, OMB
Casey Oravez, OMB, Financial Ops
Paula Roy, DCSN
Rebecca Scarborough, DRSPA
Dr. George Schreppler, DCSN
Ann Spence, DRSPA
Jeff Taschner, DSEA
Jim Testerman, DSEA-R
Jenifer Vaughn, DOI

Mike North, Aetna
Wendy Beck, Highmark
Pam Price, Highmark
Walt Mateja, Truven Consulting
Kevin Fyock, Willis Towers Watson
Chris Giovannello, Willis Towers Watson
Jaclyn Iglesias, Willis Towers Watson
Rebecca Warnken, Willis Towers Watson

Introductions/Sign In

Director Jackson called the meeting to order at 2:03 p.m. Introductions were made. The committee is in transition with one member exiting and another joining once appointed. Geoff Klopp representing COAD (Correctional Officers Association of Delaware) has resigned.

Approval of Minutes - handout

The Director requested a motion to approve the minutes from the March 6th SEBC meeting. Controller General Morton made the motion and Commissioner Navarro seconded the motion. The motion carried.

Director's Report – Brenda Lakeman, Statewide Benefits Office (SBO)

As reported in the news in recent months, EpiPen® costs have increased. SBO has taken steps with Express Scripts (ESI) to mitigate the costs. Costs for the brand EpiPen® is \$608. Myland, manufacturer of EpiPen® has created an authorized generic for the price of \$300. Last year the GHIP spent \$1M for 1,437 members. Beginning April 1st GHIP members will be required to fill prescriptions for the EpiPen using the authorized generic. Letters were sent to 357 members who had the EpiPen® filled over the last 130 days. Refills will automatically be substituted with the generic authorized product.

SBO met with Express Scripts last week for the FY17 Q2 meeting. ESI reported the change put in place for Medicare retirees – Coordination of Medicare Part B prescriptions for the period of August 1 through December 31, 2016 realized a \$280K savings which is on target with the estimated total savings of \$650K annually.

Updates around the 2017 Open Enrollment were provided with highlights on the registration for the Benefit Representative Meetings and Employee Education Sessions. Health Fair dates and rates were posted on the SBO website. Employee Education posters have been sent to all agencies and schools. SBO e-Newsletters for “What’s New” were sent March 23rd and e-Newsletters for “OE Reminders” is due out April 3rd. The Interactive Open Enrollment

Benefits Guide to be available around April 24th. Letters for the myBenefitsMentor tool are due to be mailed the week of April 17th and the online tool will be available by mid-April. Other April and May “SBO happenings” were shared.

Financial Reporting

February 2017 Fund & Equity Report - handout – Casey Oravez, Financial Operations

The GHIP received a Commercial prescription drug rebate of \$5.88M in early February contributing to the operating revenues. The Fund Equity balance is \$80.8M with \$32.8M in the minimum reserve and a claim liability balance of \$48M (to be updated to \$54M in the next report).

The Director shared that if there is a surplus at year end, the SEBC has the authority under Delaware Code to move a portion or all of the surplus to the OPEB (Other Post-Employment Benefits) fund. OPEB are benefits (other than pensions) that state and local governments provide to their retired employees. These benefits primarily involve health care benefits, but also may include life insurance, disability and other services. The State of Delaware OPEB fund is used to fund retiree health care benefits. There was discussion among the SEBC about prior instances of where the Committee elected to transfer GHIP funds to the OPEB fund. An overview of the OPEB fund and the State’s retiree health care liability as well as funding OPEB as a potential use of GHIP surplus may be discussed at a future SEBC meeting.

Highmark Care Management Models - handout - Willis Tower Watson (WTW)

Kevin Fyock provided some background on the care management models with the goal to move the GHIP toward a higher utilization of value-based care that focuses on “pay for value” rather than “fee for service”. The State will leverage these care solutions from Aetna and Highmark.

Highmark’s True Performance program for primary care physicians along with Centers of Excellence and emerging Accountable Care Organizations with the opportunity to evaluate Highmark’s care management models, play a similar role as the CCHS team managing the Aetna HMO population through AIM. Under Highmark, the State can choose:

- Intensive Model – in place today
- Customer Care Advocacy (“CCA”) model
- Custom Care Management Unit (“CCMU”) model

WTW was encouraged to hear Highmark’s willingness and future plans to further embed the CCMU program into their True Performance Network. There are linkages that Highmark can provide between value based care (VBC) and enhanced care management models in the near term. WTW will continue to bring more information as it evolves. CCMU will have customized reporting for the State allowing SBO to view the savings.

Adoption of an enhanced care management program has no negative employee impact. WTW has worked with Highmark to understand the key differences in each of these models on the State’s behalf. This includes reviewing which components of the Intensive Model are available to all Highmark customers, and which have been customized specifically for the State. Compared to the Intensive Model, the net projected savings are:

- CCA Net Savings: \$3.2M - \$4.7M
- CCMU Net Savings: \$5.5M - \$7.4M

A deeper dive into clinical model value drivers and engagement along with examples was examined.

- CCA and CCMU customer service (CS) teams receive special training on how to listen for and draw out opportunities to further engage a member in both clinical and non-clinical ways
- This differs for Intensive Model customers, who are provided Highmark’s “standard” CS team, which has not been trained on ways to act as clinical advocates, does not have access to clinical information about members, and are not measured on their performance in terms of their referrals to the nurse team and ability to drive engagement

Treasurer Simpler asked WTW to address Dr. Walker’s point about these care management programs being a good short term step, but value based delivery is not embedded. Mr. Fyock described VBC vs Fees for Service (FFS) as shifting the care from volume based (FFS) – the more patients seen, the more the providers are paid. VBC shifts the paradigm

where the provider now has a stake in the game based on the quality of care they provide and this is how they are compensated.

This enhanced care management model today is not VBC, however Highmark has the True Performance Network (TPN) which is Highmark's VBC network, and wants to find linkages to further embed the CCMU model into their TPN through reporting with the providers to better engage members and so providers are aware of what Highmark is doing and what they can do to potentially link back. While this is not in place, WTW is encouraged that Highmark recognized there are linkages that they can experience in the near future.

Ms. Magarik shared that Delaware is still primarily a FFS environment and this is an additional care management tool that will prevent expensive FFS expenses like ER visits. Dr. Walker's point was that the objective should be to move the entire healthcare system along so that we are instead trying to get to payments that are agreed upon and based on keeping people healthy as opposed to a volume type environment.

Ms. Lakeman shared 70% of the GHIP Highmark members are attributed to these True Performance contracted physicians which is positive. If working with the CCMU model with these providers and they have an incentive for VBC, they're going to be appreciative of working with these nurses and professionals to try to help manage their patients because they may not have enough resources to help manage. Ms. Warnken stated the TPN is all upside incentive. The provider has to keep costs below a certain per capita level and meet quality metrics to receive an incentive payment back in the end.

Ms. Iglesias shared that over 80% of the TPN provider metrics are overlapping with the DCHI common scorecard. Ms. Magarik briefed the Committee on the use of the common scorecard as part of the Center for Health Innovation work to provide a standard set of provider metrics to score the effectiveness of providers in meeting certain standards of care which helps to change the focus from volume based to value based care.

Mr. Fyock shared that moving to an enhanced care management model in the short term could prove to be a catalyst for a much longer term solution because of Highmark's willingness to use this as a platform to further embed it into VBC. More discussion on value based care models including presentations from Highmark and Aetna will be considered for future SEBC meetings.

Ms. Iglesias continued with an overview of the metrics and performance guarantees, clinical oversight with differences among the three models along with provider experience. Implementation of the CCMU model within 90 days, supported by WTW for a three year contract, minimum of two years with reporting available 90 days after the end of the first year. The SEBC would have the opportunity to review the benchmarks, metrics and baseline data used to measure changes. Costs associated with the models will be added to the administrative fees paid monthly and expected savings would contribute to the GHIP surplus and bending the cost curve. Savings would be greater in the out years as the impact of avoided costs would increase. A separate WTW team handles the custom care management to avoid any conflict of interest. Ms. Nestlerode expected to see a more detailed savings analysis for the CCA and CCMU models and expressed concern over the lack of any realized savings under the intensive model. The Judicial branch does not feel nurse calls are the answer to address rising costs and utilization and would like to see more discussion related to Centers of Excellence (COE) and having high quality, perhaps limited (i.e. radiology) networks. WTW will be able to provide likelihood where savings will occur and this will be clear from the scorecard that Highmark will build. A baseline will be established upon implementation and the metrics will be closely monitored to measure and determine savings both short and long term. This is another initiative to bend the cost curve. The intention is to vote on a Care Management model today to allow time for Highmark to implement by July 1st. Once a decision is made, Highmark, WTW and SBO will work to create the scorecard, an action plan and further determine transparency around the aggregate savings expected by the selected model. Secretary Geisenberger reiterated that it may take a lot of different approaches to bend the cost curve and it may take multiple things like this model along with tiered providers, VBC models, etc. It will be important for the Committee to explore these opportunities and monitor each one closely to determine how each is performing. Fees and performance guarantees were further examined. The return on investment (ROI) for CCA is 2.6% and 2.58% for CCMU. Vote to be taken after public comment.

Director Jackson remarked on the Governor's Budget Reset with the proposal to reduce the State's contribution into the employee health care fund by \$6.5M or approximately 2% with an eye towards FY2019 with future meeting dialogue to occur around this goal.

Long Term Plan for the State's Group Health Insurance Program - handout - Willis Tower Watson (WTW)

Kevin Fyock started off with a review of the long term health care cost projections through 2023 at a trend value of 6% assuming no program changes and followed with an outline of a potential path forward for a phased roll-out of key changes to the GHIP to be completed by the beginning of FY2020. Potential changes included the introduction of a HSA plan and redesign of existing plan offerings, changes to plan design and broader utilization of COEs and other value-based care delivery models, additional member cost sharing and a change in the benefits plan year from a fiscal year to a calendar year. WTW does not foresee tremendous impacts in the near term around ACA and noted the Cadillac (excise) tax was pushed back to the year 2026. There are potential items within the American Health Care Act that could have an impact but nothing WTW would consider gauging at this time. These potential impacts to be covered in future discussions as WTW will continue to bring before the committee options to bend the cost curve. Some changes will require legislative action and in some manner do relate back to the GHIP strategic framework. A more in-depth view of changing the State's benefits plan year from fiscal to calendar was presented by Jaclyn Iglesias. This may create less State costs to have one OE versus the current three OE's for health, Medicare and FSA with the multiple communications, associated costs and may provide more stability in the planning process.

Ms. Iglesias reviewed the Key changes as mapped out in six month increments for consideration along with a timeline for each phase. Changes to consider effective January 1, 2018 include begin implementation of a HSA plan (launch 1/1/19), increase member cost sharing through plan design, offer incentives for engagement in care management programs, healthy behaviors and smart consumerism, evaluate COE, adopt incremental approach to adjusting medical plan price tags for employees/pensioners, increase overall employee cost sharing target for actives/pre-65 retirees to 15%, eliminate Medicaid contribution Double State Share. Ms. Warnken noted under the Plan Design savings of \$7M reflects six months of State savings through end of FY18 (1/1/2018 – 6/30/2018). Savings from financial incentives and COE will depend on program design and member participation. Savings may be minimal in the initial year but increase over time. Longer term health care projections were reviewed with the overall trend reduced from 6% to 5% into FY2019 and then further to 4% in FY2020 and beyond with just the changes implemented January 1, 2018. As the changes for each six month period are covered, WTW refreshed the cost projection graphic to view impact through each change.

The next increment of GHIP changes effective July 1, 2018 included renegotiate benefit plan contracts, continue implementation of a HSA (launch 1/1/19), conduct an Active Enrollment for FY19 for a short plan year (7/1/18 – 12/31/18) to accommodate a CY plan year starting January 1, 2019, determine changes to plan designs, incentives for CY19, explore and implement medical TPA programs to support utilization management (i.e. tiered pricing for lab services), continue adjusting medical plan price tags and increase employee cost sharing.

The last six month period includes changes effective January 1, 2019 would include the launch of HSA plan, conduct Active Enrollment, consider additional plan design changes, increase member cost sharing and encourage value-based care delivery models, continue adjusting medical plan price tags and increase employee cost sharing and implement surcharges for tobacco use. The cumulative impact for all the changes add to \$5M one time savings in FY19 through implementation of the HSA plan and are carried forward in future years looking at a 4% trend in 2020. Even with these changes the rate of growth for the GHIP would still be greater than the State's rate of revenue growth for the next two fiscal years and still require revenue from the State to support a 4% trend line in health care costs.

Director Jackson invited committee members to bring forth any other options and suggested an interim meeting to be held April 10th to continue examining these options. Treasurer Simpler added that seeing an additional two preceding fiscal years as part of the annual budget may provide additional data to assist the SEBC in seeing changes and trends in GHIP revenue and expenditures.

Public Comments

Mr. Jim Testerman, DSEA-R, shared his history on the Pension fund and his past involvement with the State's OPEB fund. At first, the State employee's contribution rate to the Pension fund was 8%. With good management, the fund was funded in 25 years and the employee contribution was lowered to 3%. Now the contribution rate is 5% and prefer to see it reduced to 3% with the extra 2% going into the OPEB fund. He realizes that finances need to be more stabilized before doing this but would be a good direction to head toward.

Ms. Rebecca Scarborough, DRSPA shared her concern about the SEBC voting on changes to improve the financial situation for the GHIP that might include penalizing doctors or providers for their performance or level of patient care as this is sometimes not something that providers can control. She shared a personal experience and mentioned how physicians also have choices in terms of participating in insurance provider networks and asked the SEBC to remain mindful of this as they consider options to reduce the financial burden and the individuals their decisions will impact.

Other Business

None

Motions

The Director entertained a motion for the implementation of the Highmark CCMU Model effective July 1, 2017 with some understanding around the reporting, benchmarks and baseline for the savings going forward. Secretary Geisenberger made the motion. Treasurer Simpler clarified the dollars at risk are \$492K for the CCA for an average benefit of approximately \$3.5M. For the extra \$360K in fees, there is an extra \$2.5M in potential benefits. Ms. Magarik seconded the motion. One member, Evelyn Nestlerode, opposed the motion. Motion carried.

An interim meeting is tentatively scheduled for Monday, April 10th at 2pm. Notification will be made once location is confirmed.

Director Jackson requested a motion to adjourn the meeting. Ms. Magarik made the motion and Controller General Morton seconded the motion. Meeting adjourned at 4:16 pm.

Respectfully submitted,

Lisa Porter
Statewide Benefits Office