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

The State Employee Benefits Committee met July 23, 2018. The following people were in attendance:

Committee Members:
Mike Jackson, OMB, Chair
Bethany Hall-Long, Lt. Governor
Saundra Johnson, DHR
Evelyn Nestlerode, Designee of Chief Justice, Administrator of Courts
Ken Simpler, OST
Stuart Snyder, Designee for DOI
Jeff Taschner, DSEA
Kara Walker, DHSS

Guests:
Brenda Lakeman, Director, Statewide Benefits Office (SBO), DHR
Faith Rentz, Deputy Director, SBO, DHR
Lisa Porter, SBO, DHR
Paul Biery, DRSPA
Jennifer Bredemeier, Univ of DE
Steven Costantino, DHSS
David Craik, Pension Office
Barry Dahllof, Christiana Care
Cherie Dodge-Biron, DHR
Jamesha Eaddy, City of Milford
Jacqueline B. Faulcon, DRSPA
Geoff Heath, Christiana Care
Tina Hession, PHRST
Leighann Hinkle, SBO, DHR

Guests (continued):
Lisa Jaremka, Univ of DE
Kimberly Jarrell, DHSS
Art Jenkins, CGO
Elizabeth Lewis, Hamilton Goodman Partners
Miranda Mal, DOC
Mary Kate McLaughlin, Drinker Biddle
Regina Mitchell, OMB
Bill Oberle, DSTA
Paula Roy, DCSN
Tabassum Salom, Christiana Care
George Schreppler, DCSN
Jim Testerman, DSEA-R
Elizabeth Lewis, HGP

Roy Caviness, Aetna
Katherine Impellizzeri, Aetna
Mike North, Aetna
Tim Constantine, Highmark
Lisa Mantegna, Highmark
Jennifer Mossman, Highmark
Pam Price, Highmark
Kevin Fyock, Willis Towers Watson
Chris Giovannello, Willis Towers Watson
Jaclyn Iglesias, Willis Towers Watson
Varvn Sirakumar, Willis Towers Watson
Rebecca Warnken, Willis Towers Watson

Introductions/Sign In
Director Jackson called the meeting to order at 2:01 p.m. Introductions were made.

Approval of Minutes - handout
The Director entertained a motion to approve the minutes from the June 25th SEBC meeting. Treasurer Simpler requested more clarity around the health care projections and then made the motion to approve. Secretary Walker seconded the motion. The motion carried unanimously.

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

2018 OE Membership Changes: This consists of the enrollment changes from June to July for all of the vendors. Survey responses are not yet analyzed and will be brought to the next meeting.

Delta Dental: The amendment to provide for assignment of benefits to out-of-network providers has been executed and the process will begin on September 1st.

DIP RFP: SBO has received five intents to bid from The Hartford, Prudential, MetLife, The Standard and Lincoln Financial. Those bids are due August 10th.

Legislative Updates:

- SB139 IVF Coverage: Will be asking SEBC to take action on, requires the health insurance offered in the State provide coverage for fertility care services including IVF which is currently offered with limits of $10K for medical and $15K for prescription. The action requested would be without limits as well as provide cryopreservation for those

diagnosed with cancer and other diseases when medically necessary. Effective date was set for June 30th. Additional information will be brought to the committee at the next meeting on utilization costs and additional services to determine if SEBC wants to add these services at an unlimited benefit and with additional benefits to the plan. Mr. Taschner added the coverage this bill requires has the potential to reduce the likelihood of multiple births as a result of IVF, as some of these births contribute to the high cost claims, and hopes the additional information includes an attempt of how expanding coverage would cost and potentially the savings in the long run.

- SB151 Contraceptive Coverage: Changes to the plan require providing for a 12 month supply to be filled at one. Also requires coverage of emergency contraceptive drugs over the counter without a prescription. This will require some manual intervention with SBO and ESI. SBO will be developing this procedure.
- HB319 Coverage for Experimental Procedures: Something that is treated that is no longer experimental or investigational by CMS and Medicare covers it, Delaware will no longer be able to deny coverage on that basis. Carriers believe there will be no real fiscal note to this Bill.
- HB3 Family Leave Act: Provides twelve weeks of paid leave for birth or adoption of a child under six. The only impact with the disability program making sure all runs concurrently and will be working closely with DHR to make sure the implementation is smooth.
- HB425 Permits Prescription Disclosures: Pharmacies can provide the cost share and information on drugs to the insured and if there's a more affordable or therapeutic Rx drug available – no impact to the plan.
- HB386 Charlie's Law: Is to provide coverage for treatment with IVIG for Pediatric Autoimmune Disease Neuropsychiatric Disorders with strep infections. Estimated impact of $100K or more. Currently do not have any of the population receiving coverage for this diagnosis.
- SB227 Primary Care Coverage – To be reimbursed at Medicare rates effective January 1, 2019.
- SB225 Non-Opioid Treatment – coverage for non-opioid treatment for back pain in removing all limits on physical therapy and chiropractic treatment. To be effective depending on funding. The fiscal note for 6 months $87.5K and for a full year starting FY20 is $175K.

The changes in the 2018 OE membership were factored into the budget where adoption of SB139, SB225 and SB227 would need to be factored into the longer term forecast with additional conversation among SEBC.

Group Health Financials

Fund Equity Report – (F&E) June 2018 – handout - Willis Towers Watson (WTW)

June showed another positive month for the closeout of FY18. A few highlighted items include under Other Revenues for $491K where $480K is the overpayment credit for the 3D Mammography. Under the Operating Expenses, claims came in $1.8M below budget. The F&E balance closed the fiscal year at $151.8M, leaving a variance of almost $69M over and above reserves. WTW will look at July's claims to see if there is any delay in services being processed that did not show in June's F&E, and will review not just the comparison to the budget rates, but to the WTW budget that was set at the beginning of last fiscal year and how its running against that budget.

FY19 Budget Approval

This is updated with experience through end of Q3 using the same assumptions as previously discussed at pricing and budget discussions and also updated with the open enrollment accounts as of July. With a $22.6M in deficit, this will bring the F&E balance down to $129.2M at the close of the fiscal year. Some of the elements were discussed. Data will be available through June to allow for an updated F&E report and some modification to the budget to account for some legislative changes.

Motion

Director Jackson entertained a motion for a preliminary action allowing time for an updated F&E report, and to adopt legislative changes into the budget for final approval at the next meeting. Secretary Johnson made the motion and the Lt. Governor seconded the motion. The motion carried unanimously.

WTW will provide the updated FY19 budget along with a reforecast of the multi-year outlook.

Value Based Contracting (VBC) Update – handouts **–** Highmark & Aetna

Highmark VBC – Kevin O'Hara, Director of Provider Relations and Servicing

Highmark's approach to Value Based Reimbursement (VBR) was shown in a spectrum of their partnership models. Highmark's multi-pronged approach to value-based care and reimbursement was presented with True Performance (TP) introduced in 2016, True Performance Plus in 2017, and True Performance Advanced is rolling out in 2018. Highlights include developing custom programs with health systems, independent specialists and other providers with a proliferation of VBR mechanisms and developing partnerships with provider organizations to continue on advancing value based care. Specialists are transitioning to risk-based programs such as Bundled Payments and Specialist Efficiency. Efficiencies for Specialists are defined related to costs. Quality Blue Health hospitals have existed in this marketplace for long time with Nanticoke, Beebe, Bayhealth, Crozier and St. Francis which is a facility based quality program. St. Francis scored perfectly in 2017, one of only 19% hospitals in the Highmark family. Highmark to provide stats on non-TP programs.

True Performance is making an impact in Delaware with 73% of eligible practices participating in TP, 70% of eligible PCPs participate in one or two performance programs and 72% of members seek care from a TP PCP. Quality scores increased by more than 40% from Q1 to Q4. Illustrative graphs show TP members outperformed non-TP members in 2017 on cost and utilization metrics show TP SOD members costs are $25 PMPM less, had 16% fewer admits/1000 and 16% fewer ED visits/1000. TP is supported with significant data and analytics, supplemented by other value-based initiatives to encourage coordination. They are meeting with hospitals on a quarterly basis. A 3-year reimbursement roadmap was shown that spans across the care continuum and the increase of value within Highmark as a whole. Under the 2019 category, programs currently in place in Delaware are to expand High Value Networks, to link member education and transparency programs to VBR, to expand QBH to more episodes and other value drivers, and implement Site of Care programs. Highmark was prompted to share with the Committee a score card on the providers with in Delaware where providers currently are and if willing to move from the old fee-for-service model toward these types of new models. Adoption issues exist relative to incentive programs that may ultimately replace fee-for-service. Highmark just paid out 2017 where a lot of providers realize the gains of these models. The expansion of prospective bundles through 2019-20 will be seen specific to specialists with efficiency metrics to be provided. Partnership examples (Nemours, CCHS, and United Medical) were revealed along with Delaware VBR Future State.

Aetna – Value Based Continuum – Ron Caviness

Aetna plans to have 75% of spending committed to value-based care models by 2020. Aetna meets providers where they are in their journey to build sustainable collaborations. Comparison of value-based models was examined. The reimbursement models include Pay-For-Performance (P4P), Patient Centered Medical Home (PCMH), Bundled Payment, and Accountable Care Organization (ACO). There currently are no PCMH or ACO's as defined in Delaware but they are in discussions for those models. Reimbursement with health plan products include ACO product and joint venture. Aetna has five joint ventures across the country. Penetration in Delaware shows 58,789 Aetna members included in VBC arrangements representing 45% of total Delaware membership. Participating providers in Aetna VBC arrangements representing 50% or 2,400 of the total Aetna Network of Providers in Delaware. AIM HMO is the model designed exclusively for the State of Delaware GHIP Aetna HMO members and is supported by CareLink CareNow. Aetna just executed their first Bundled payment with the HMO with Christiana Care. Initially this is specific to knees, hips and spine yet will continue to grow to bariatric and/or other opportunities. Additional information on Aetna's Bundled payment service was provided which is a defined episode of care, procedural or diabetes or total knee replacement. Example of a Bundled payment consists of orthopedic surgeon, facility costs, anesthesia, supplies, implants and extend to a warranty period of 30-60-90 days post-surgery along with post-acute care. Price transparency is the biggest benefit to provide members upfront of the cost of a procedure. Aetna's bundles definition is similar to the CMS definition while allowing room for flexibility. There's an opportunity to share in the savings. Collaborative relationships in Delaware and Pennsylvania were shared. Aetna doesn't have a full year's worth of data yet but can share those participating in VBC programs on the cost and quality side versus differentiation with the non-participating groups. A look at the historical data is used to set the bundled price. Christiana Care and the bundled payments is just with the HMO. Some out-patient surgery centers are negotiating bundled payments where other hospitals are not negotiating at this time.

Clinical Management Update – handout - Willis Towers Watson (WTW)

This is an update of member overall engagement in the enhanced clinical programs provided by Aetna and Highmark that the SEBC voted on in the spring 2017. Later in the fall, WTW will have a full plan year of data to present. An overview of each of the plans' programs was covered. Initial engagement results were reviewed for each program. Direct comparison of the programs is not possible due to differences in each program's structure and execution. Metrics were reviewed to evaluate the effectiveness of each clinical program. Dialogue with each vendor regarding reporting capabilities is necessary prior to confirming specific metrics for the SEBC. Timeline for evaluating broader impact was shown. Initial engagement results were reviewed for each program with highlights below:

Aetna VBC-CareLink CareNow (HMO plan) –

- Time period of July 2017 through June 2018:
- Engaged 5,641 unique members with total of 5,069 condition-specific programs launched
- 67% completed the program duration of 100 days; 20% inability to reach member
- Through April 2018, 55% of the highest cost and/or highest risk claimants or 725 members were engaged with CareLink
- ER use shows 809 members with high ER use, CareLink engaged 576 members (71%)
- 334 of the high ER utilizers completed Care link's transition of care program with an end result of fewer ER visits

Aetna Traditional case and disease management for CDH Gold plan participants

- Time period of July 2017 through March 2018
- Fewer than 10 members targeted for case management; none have engaged
- During each quarter in FY18, Aetna identified an average of 7% of enrolled members (300 people) for disease management; fewer than 2% of those (5 members) actively engage
- This reflects typical stats seen with a traditional disease management plan with a smaller population

Highmark CCMU –

- Time period July 2017 through March 2018
- 4,083 unique members identified with 72% or 2,955 reached and 75% or 2,209 engaged. CCMU nurses have been able to engage at least 50% of high cost claimants (>$50K claims) each quarter
- Reductions in avoidable ER use among engaged members has been reported
- A 95.8% satisfaction rate based on 78.4% survey response rate for total of 1,815 completed surveys

Further dialogue around robust stats, cost avoidance estimates to understand from a dollar perspective and the difference of being engaged and participating in a care management program to continue in future meetings.

Centers of Excellence (COE) – handout – Faith Rentz, SBO, DHR

The Proposal Review Committee (PRC) met July 18th for an in-depth analysis of the bid responses received from the two bidders as finalists. Interviews were conducted. Further input from the SEBC is required to determine path forward. Key questions were reviewed for each committee member to discuss with appointed PRC designee. Additional considerations with comments from SBO and WTW for the SEBC were explained in great detail. The PRC scoring meeting is scheduled for July 25th. A request for more information on how these COE's operate in other jurisdictions and an opportunity to hear from the TPA's and Health Care Association on their experience was made. Further discussion to continue including determining the effective date as a six month time frame is needed for implementation. The final presentation to the SEBC and vote on award recommendation is flexible.

Other Business

Director Jackson shared the idea of forming a subcommittee within SEBC to further examine topics in the financial and/or planning side with designees and provide detailed recommendations to the SEBC members. The subcommittee meetings will be public meetings. The SEBC members indicated agreement. A proposal will be forthcoming.

Public Comments

Lisa Jaremka, Professor, University of Delaware representing herself and other state employees to advocate to the SEBC to adopt SB 139. Ms. Jaremka provided a petition of 200 signatures obtained from employees that are in favor of adopting this bill along with letters from people sharing their story on this subject and how SB 139 will impact them. Ms. Jaremka provided a handout on how adopting SB 139 would make good financial sense and create a competitive advantage that the State would have in hiring, retaining and supporting employees.

Bill Oberle, DSTA, shared his primary care physician (PCP) already manages his care. It would be valuable to obtain the data that establishes how many people in the State have a primary care physician and if we can provide an incentive like an on-site facility mechanism to have employees obtain a PCP, we could bend the curve in the right direction.

Miranda Mal, DOC suggested to foster transparency, add the subcommittee minutes into the agenda for the SEBC committee.

Motion
Director Jackson asked for a motion to adjourn the meeting. Secretary Johnson made the motion and it was seconded by the Lt. Governor. The motion carried unanimously. Meeting adjourned at 4:10 p.m.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office, DHR