

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

The State Employee Benefits Committee met December 10, 2018. The following people were in attendance:

Committee Members:

Mike Jackson, OMB, Co-Chair
Bethany Hall-Long, Lt. Governor
Tanner Polce, Designee of Lt. Governor
Saundra Johnson, DHR, Co-Chair
Mike Morton, CGO
Trinidad Navarro, DOI
Evelyn Nestlerode, Designee of Chief Justice, Administrator of Courts
Jeff Taschner, DSEA
Kara Walker, DHSS
Molly Magarik, Designee of DHSS

Guests:

Faith Rentz, SBO, DHR
Leighann Hinkle, SBO, DHR
Bridget Wallace, DHR
Victoria Brennan, CGO
Cherie Dodge Biron, DHR
Lynette Maxwell, PHRST, OMB
Andrew Kerber, DOJ
Jacqueline Faulcon, Lobbyist
Martha Sturtevant, OST
Jim Testerman, DSEA- Retired

Guests (continued):

Bill Oberle, DSTA
Judi Schock, OMB
Aaron Schrader, SBO, DHR
George Schreppler, DCSN
Kim Hawkins, City of Dover
Julie Caynor, Aetna
Judy Grant, Health Advocate
Lisa Mantenga, Highmark
Jennifer Mossman, Highmark
Pam Price, Highmark
Walt Mateja, IBM Watson Health
Chris Giovannello, Willis Towers Watson
Jaclyn Iglesias, Willis Towers Watson
Rebecca Warnken, Willis Towers Watson
Dave Craik, Pension Office, OMB
Christina Bryan, DHA
Jill Hutt, GPBCH
Susan Steward, OST
Jennifer Bredemeier, UD
Steven Costantino, DHSS
Aditi P. Sen, Johns Hopkins
Ge Bai, Johns Hopkins
Rick Geisenberger, Finance
Wayne Smith, DHA

Introductions/Sign In

Director Jackson called the meeting to order at 2:04p.m. Introductions were made.

Approval of Minutes - handout

Director Jackson entertained a motion to approve the minutes from the November 13, 2018 SEBC meeting. Controller General Morton made a motion to approve the minutes and Secretary Johnson seconded the motion. The Motion carried unanimously.

Director's Report – Faith Rentz, Director, Statewide Benefits Office (SBO), and DHR

Subcommittee Update – Individuals serving on the Benefits Committee and Subcommittees have entered into conflicts of interest statements with regards to and acknowledging that they are registered lobbyists. SBO is working with DOJ on whether or not there is an additional need for conflict of interest statements from other members of the Benefits Committee and Subcommittees.

Health and prescription audit update – SBO is working with CTI and Tricast to conduct an audit of the group health plan and prescription drug plan for FY17 & FY18. SBO has received a draft of the medical reports that will be reviewed with the Health Policy & Planning Subcommittee in early 2019. A draft report is expected for the prescription plan in May. We are in contract negotiations with Express Scripts for year four of our contract for the prescription drug management. We expect to have the outcome of those negotiations and any anticipated savings for FY20 to bring before the Committee in early February.

Dental and Vision rates for FY20 – We are in year four of both contracts. These are both fully insured plans and the dental plan was procured with a three year rate guarantee. There is an increase anticipated in these plans as per the

negotiated contract for July 1, 2019. We will provide updated premiums to the group in early 2019. The vision plan has a negotiated increase for year five (July 1, 2020).

Senate Bill 225 – This Legislation removed caps for members with lower back pain for physical therapy and chiropractic benefits under the state plan. We will comply with the legislation as required, effective January 1, 2019. Additional language in the legislation requires notification by the Director of OMB that funding was secured and available, and that it be recorded with the Register of Regulations. That was submitted and will be published in January.

Assignment of benefits with Delta – Amendment made (effective September 1, 2018) to allow for non-participating Dental providers to submit their bill directly to Delta for direct reimbursement rather than reimbursement to the member. We asked Delta to provide quarterly updates of changes to the network resulting from the assignment of benefits provision. To date, they have received some calls and inquiries from both providers and members with regards to the attestation that members are required to execute prior to the provider submitting their claims for reimbursement. There have been a few instances where providers are questioning why they must provide the attestation to their members. A few instances reported to SBO where members were not executing the attestation; however, that has not been reported to Delta. There are a few non-participating providers who have inquired about joining the Delta network. SBO will provide updates of when and if contracts are signed, as well as any providers who choose to leave the network as a result of this provision.

Centers of Excellence Implementation Update – SBO is working to compile and provide data to SurgeryPlus, the awarded vendor. We're hoping to do that within the next several weeks. That information is needed for them to continue developing proposed plan design, and incentive and engagement proposals that will be further evaluated by the Health Policy & Planning Subcommittee.

Announcement - CVS acquired Aetna, no change in our relationship. SBO will provide updates as they become available.

2019 National Preferred Formulary- Packet (not reviewed at meeting)

High level overview of the formulary changes that will go into effect for both commercial and employer waiver prescription benefit plans effective January 1, 2019. Express Scripts makes changes to the formulary yearly to ensure that their clients are receiving the most competitive pricing for drugs listed on the formulary. Members that are impacted by those changes will receive a letter from Express Scripts notifying them of the change and any interactions they may need with their physician.

Subcommittee Updates- Faith Rentz- handout

December 4th Health Policy & Planning Subcommittee meeting – potential options to further differentiate copays and out of pocket expenses for sight of care services (imaging, lab, urgent care). Additional options discussed included infusion therapy (under the Highmark plan). These discussions will continue at the December 18th meeting as well as diabetic and pre-diabetic services that might be available for the next fiscal year. This group will formulate a recommendation for those site of care steering options and additional care options for the January SEBC meeting.

December 4th Financial Subcommittee meeting– continuing to discuss the potential to adjust the reserve funding and to contemplate whether or not the surplus funding could be used over multiple years as opposed to using the entire amount for FY 20 planning. Those discussions will continue on December 18th as well as the impact (percentage and dollar amount) of various premium increases and how they affect both the state and the employee. The financial subcommittee will provide a recommendation for the SEBC at the January meeting.

Executive Order 25– Handout - Healthcare Spending & Quality Benchmarks Overview, Dr. Kara Walker, DHSS

The Executive Order was signed by the Governor on November 20, 2018 and is a transparency measure to help guide and give information about where long term trends should or could be. This EO also establishes a subcommittee of DEFAC for setting the health care spending benchmark for calendar year 2019. It will be between 3.8% and 4.0%. Subsequent calendar year benchmarks will be set on this trend, which starts in 2020 at 3.5% and decreases to 3.0% by 2022. The calculation and details are in the EO. The EO also establishes various health care quality benchmarks such as

Emergency Department utilization rate, opioid-related overdose deaths, adult obesity, etc. On January 31, 2019 DHSS will publish a technical manual with the methodology for calculating the spending and quality benchmarks. On May 31st of each year, the DEFAC will report to the Governor and the Health Care Commission any changes to health care spending. In the 4th quarter of each year, the Health Care Commission will report on performance relative to the spending and quality benchmarks. There are no specific links with state health care as of now, but these benchmarks can be used as guidelines in discussions specific to growth trends and targets.

Ms. Rentz advised the Committee that SBO is reviewing the quality benchmarks and will provide updates at a future meeting.

Healthcare Cost Landscape Analysis & Discussion – Handout – Aditi P. Sen, PhD, Johns Hopkins Bloomberg School of Public Health and Ge Bai, PhD, CPA, Johns Hopkins Carey Business School

Dr. Sen and Dr. Bai are part of a grant funded team that does work to support and inform State level efforts to lower private sector prices. This is a preliminary analysis of the State's inpatient hospital prices compared to Medicare. This presentation showed initial results of this study, and asks for feedback and requests for other types of analysis.

The goal of their analysis was to demonstrate the price variation across inpatient services to look at variation in prices across geographic regions (specifically the metropolitan statistical area or MSA level), types of patients, and types of plans, to compare private prices to Medicare and to demonstrate the extent of practices that increase prices for patients (out of network billing). This presentation featured data on average inpatient prices overall and for selected procedures in Delaware, variation in prices across the MSAs in the state and a comparison of unadjusted commercial and Medicare prices in Delaware. It was noted that no risk adjustment has been completed, but that adjustment will be made going forward. The SEBC will be given these results at a later time.

The Market Scan data is from 2012-2016 and includes data from about 350 different insurers across the country. This data set captures active employees, early retirees, dependents that are insured by contributing employer sponsored plans. The analysis included a sample of 130,000 Delawareans ages 18-64 in regards to inpatient admissions. The main outcome was the total spending per admission and by service. The data showed a small increase in private prices of average inpatient admission in Delaware over time and that private sector prices are twice as much as Medicare prices. Hospital costs vary in response to different pressures, but they are flexible and hospitals respond by lowering their costs. The average Medicare margin in 2016 for efficient hospitals was -1%. The average marginal Medicare margin in 2016 was 8%. Hospitals earn a profit on each additional Medicare patient. The analysis looks at data showing that DE Hospital Profitability is better than the US average. The Committee was presented with policy considerations for the State of DE Group Health Program and some next steps.

Dr. Walker asked what other states has John Hopkins worked with on a similar analysis and was advised both Montana and California. Secretary Johnson asked if this information (from other states) is transferable and was advised that we have to keep in mind the consideration of the market and that states are governed by different laws, policies and regulations. Secretary Johnson also asked if there has been any innovations on the providers side and was told that it is difficult to find at the state level; however, in Connecticut, a trend in facility fees was identified. Dr. Walker inquired if there were any other things that Delaware should take into consideration when looking at Medicare costs and was told that since DE is a highly concentrated market, there may be some opportunities for change. The group discussed looking at similar data that includes the regions surrounding Delaware. Ms. Nestlerode inquired about the Certificate of Need process and was advised that this is a requirement for certifying the need of something before allowing a facility to open. There is evidence that the Certificate of Need process is not doing what it was intended to do and has contributed to increased consolidation.

The John Hopkins team will update the analysis to include the risk adjustment, information from other regions and other information that they deem useful. They will come back with updated results in early 2019.

Financials

October Fund Equity Report – Chris Giovannello – handout

October was a high claim month. We saw \$4.1M of claims in excess of our October budget. Year-to-date we are at an \$11.2M deficit, our fund equity balance has been reduced from about \$157M to \$146M. There is a new chart that was approved by the Financial Subcommittee, which gives us a new way of looking at our year-to-date surplus or deficit relative to our reserve levels. Year-to-date budget, we're at a \$53.1M surplus and actual is \$61M, so there is a \$7M additional surplus being generated by the fund through October.

FY19 Qtr 1 Financial Reporting (July through September) – Chris Giovannello – handout

Year-to-date Q1 compared to FY18 Q1, there's a 10.2% increase for overall total program costs, which translates to 8.5% per employee per year basis. Q1 of FY18 had unusually low claims which was driven by plan migration and member shift in the first year of the new contracts. If we look at FY19 Q1 relative to our budget, overall program cost is down 5.6%, on a per employee per year basis it is down at 5.8%.

GHIP Long Term Projection Recast- Rebecca Warnken– handout

The data has been updated to reflect through Q1 FY19 (Sept 2018) and does not yet capture October. The last quarter we were showing \$932M of operating expenses for FY19, that's down about \$10.5M. The decrease is driven by the improvement in the claims experience. When we look ahead to FY20, our projected operating expenses are at \$986M (about \$1 billion last year, about a \$14M decrease). That's based on 5% healthcare trend. We're now factoring in savings for the implementation of Surgery Plus for FY20 (about \$500,000 in savings). We're also factoring about \$2.4M from the legislative bills that have been adopted. Where we were in a projected deficit in FY20, we're now projecting a \$3.5M surplus. That is assuming a 2% increase in premiums annually, which is what we have been modeling and will continue to be discussed with the Financial Subcommittee. The 2% increase is a \$6 to \$66 per year increase in premium costs for active employees depending on your coverage level or plan election. SBO would like the Committee to vote in February on whether or not there will be a premium increase for FY20. The goal for both Subcommittees is to have a package of various recommendations for the SEBC to consider in January.

Other Business- None

Public Comments - Wayne Smith, DE Healthcare Association

It is important to look at operating costs. Those costs are more predictable. There is interest in the competitive environment in our state. Reports show that DE is 2nd least competitive state in the country for health insurance. Consider looking at this market and what DE is paying.

Mr. Oberle stated that he would like for the Financial Subcommittee to work more closely with Johns Hopkins.

Motion

Director Jackson asked for a motion to adjourn the meeting. Lt. Governor Bethany Hall-Long made the motion and it was seconded by Secretary Ross Johnson. The motion carried unanimously. Meeting adjourned at 3:45 p.m.

Respectfully submitted,

Bridget Wallace
DHR