MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
AUGUST 26, 2019

The State Employee Benefits Committee (the "Committee") held a meeting on August 26, 2019 in Room 112 of the Tatnall Building located at 150 Martin Luther King Jr. Blvd. Dover, Delaware 19901.

Committee Members Represented or in Attendance:
Secretary Saundra Johnson, Department of Human Resources ("DHR"), Co-Chair
Ms. Judy Anderson, Asst. Exec. Director, Delaware State Education Association (Designee OBO Mr. Taschner)
Ms. Amy Bonner, Deputy Director, Office of Management & Budget ("OMB"), (Designee OBO Director Jackson)
Mr. Steve Costantino, Department of Health and Social Services ("DHSS") (Designee OBO Secretary Walker)
Controller General Mike Morton, Office of the Controller General ("CGO")
Mr. Stuart Snyder, Chief of Staff, Department of Insurance (Designee OBO Commissioner Navarro)
Ms. Susan Steward, Policy Analyst, Office of the State Treasurer ("OST") (Designee OBO Treasurer Davis)
Ms. Ashley Tucker, Staff Attorney, Administrative Office of the Courts (Designee OBO Chief Justice Strine)
Mr. Keith Warren, Office of the Lieutenant Governor (Designee OBO Lieutenant Governor Hall-Long)

Others in Attendance:
Director Faith Rentz, Statewide Benefits Office ("SBO"), DHR
Deputy Director Leighann Hinkle, SBO, DHR
Deputy Attorney General, Andrew Kerber, Department of Justice, SEBC Legal Counsel
Mr. Kevin Fyock, Willis Towers Watson
Mr. Chris Giovannello, WTW
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Mr. Andrew Brancati, Highmark Blue Cross
Ms. Victoria Brennan, CGO
Ms. Rebecca Byrd, The Byrd Corp
Mr. Sean Burns, Highmark Delaware
Mr. Larry Copenhagen, Retired State Employee
Mr. Dominic Cottone, IBM Watson Health
Mr. David Craik, Pension Administrator, Office of Pensions
Ms. Tammy Croce, DE Assoc. of School Administrators
Ms. Cherie Dodge Biron, Conroller, DHR
Ms. Nina Figueroa, Policy Analyst, SBO, DHR
Ms. Tina Hession, PHRST, OMB
Ms. Katherine Impellizzeri, Aetna
Ms. Megan McNamara Williams, DE Healthcare Assoc.
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walt Mateja, IMB Watson Health
Ms. Sharon Miller, Administrative Specialist, SBO
Mr. Nick Moriello, Highmark Delaware
Mr. Mike North, Aetna
Mr. Kevin O'Hara, Highmark Delaware
Mr. Robert Rodriquez, IBM Watson Health
Ms. Shari Sack, Aflac
Ms. Carrie Schiavo, Delta Dental
Ms. Judi Schock, Deputy Principal Assistant, OMB
Dr. George Schreppler, DE Chiropractic Services Network
Ms. Christine Schultz, Parkowski Guerke & Swayze
Ms. Martha Sturtevant, Executive Assistant, SBO, DHR
Mr. George Testerman, DSEA, Retired
Ms. Barbara Testerman, Retired State Employee
Ms. Emily Thomas, Fiscal & Policy Analyst, OMB
Mr. Peter Trusz, Aetna
Mr. Andrew Wilson, Morris James
Ms. Lizzie Zubaca, Hamilton Goodman Partners

CALLED TO ORDER
Secretary Johnson called the meeting to order at 2:00 p.m. and introductions were made.

APPROVAL OF MINUTES – SECRETARY SAUNDRA JOHNSON
A MOTION was made by Ms. Bonner and seconded by CG Morton to approve the minutes from the June 10, 2019 State Employee Benefits Committee meeting.
MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ

Open Enrollment Statistics:

Dir. Rentz updated the Committee on final overall statistics from the 2019 Open Enrollment. She reported that participation was 84.7%, an all-time high. Video highlights are available for each organization upon request. Agency participation in the myBenefitsMentor consumer decision tool came in at 27.7% overall.

GHIP Plan Updates:

There has been a steady increase in enrollment in vision, dental, and health plans, with the exception of the Dominion Dental Plan and the Aetna HMO Plan.

July 1 Plan Changes

The Livongo remote diabetes monitoring program has 1085 new enrollments.

The Surgery Plus medical concierge program has 30 open cases as of 8/21. There were 59 first time calls for July. ID cards mailed last week are expected to increase enrollment.

Changes to Site of Care copays have not resulted in concerns from local members, however several retirees have expressed concern about access to lower cost lab and imaging services in areas outside of Delaware. SBO is assisting on a case-by-case basis.

SBO Updates

The SBO Bulletin has a new format. The first addition was sent mid-August and will be sent monthly thereafter. A SEBC Corner in each edition will highlight the work of the Committee.

SBO has added three new positions. Two training positions, and one IT position to support critical functions around COB administration, Group Health insurance Plan (GHIP) databases and ACA reporting.

RFP Updates

The Infertility Administration RFP was released and there are confirmed bidders. Recommendations are expected to be brought before the Committee in December.

The Supplemental Benefits RFP is set to advertise on August 30, 2019.

Contracting Updates:

Contracting has been finalized for Aetna, Express Scripts and Highmark for FY20. There is a preliminary contract in place with SurgeryPlus. SBO continues to work through the contract with The Hartford that will include an onsite Hartford resource to work with SBO on the administration of the disability program.

A letter sent from SBO to Highmark and Aetna requesting detailed information on the arrangements in place with hospitals. The request was refused by both Highmark and Aetna citing confidential & proprietary language in these contracts.

Dir. Rentz noted that the agenda includes a discussion on contracting methods and strategies, and the Committee will move into Executive Session with Highmark for a portion of the meeting. The discussion will continue with the Subcommittees.

WTW is working on a detailed analysis comparing GHIP claims data to Medicare, and will present findings to the Committee.

SBO is participating in a study with the RAND group to compare hospital prices on a national basis. A final report is expected in January.

8/22 Subcommittee Updates

The Financial Subcommittee reviewed the financial materials to be presented today.

The Health Policy & Planning Subcommittee began discussions related to Primary Care Provider ("PCP") access and options for the Committee's consideration. The Subcommittee reviewed and provided feedback on the PCP survey that SBO will send in September to employees enrolled in a GHIP. The Subcommittee was scheduled to review integrated wellbeing initiatives, including financial wellness and short term loan options, but the discussion was tabled due to time constraints.

The Subcommittees are scheduled for a joint meeting on September 19, 2019, where they will continue to discuss healthcare contracting.

FINANCIALS – MR. CHRIS GIOVANNELLO & MS. REBECCA WARNKEN, WTW

May & June Fund Reports

May had an increase in the amount of rebates paid, including $9.6M Commercial and $6.2 Employer Group Waiver Plan (EGWP). The increase in payments and the renegotiated ESI contract are reflected in budget projections. May claims came in $4.9M below budget.

June came in $6.4M below budget for a total of $29.0M below budget. The Fund Equity Balance is $164.0M for a favorable year end.

FY19 Q4 Financial Reporting

There was a 5.5% increase in the total program costs driven by a 1.4% increase in members. The medical spend per member per year went up 3.4% favorable to budget. Pharmacy went up 6.7% favorable to budget. Favorable claims experience in Q4 was driven by increases to rebates and improvements to expected EGWP payments. There was $15.1M net income generated in FY19 that is trending at 4%.

There continue to be increases in preventive care visits across all age groups. High Cost Claimants (members with claims over $100K) has slowed to a 2% increase in claimants per thousand. Specialty pharmacy claims increased 3%, and is a result of a 20% increase in utilization, but offset by 2% decrease in cost of prescriptions. Inpatient admissions decreased, but was offset by a 6% increase in admission expenses.

Mr. Costantino asked if more data was available to determine if higher inpatient admission costs were a result of severity or the increase in the cost of care. Ms. Warnken responded yes, and that additional incurred reporting will be available for evaluation in November.

FY20 GHIP Budget

The budget proposed for FY20 is based on 24 months of claims experience. There is a 5% trend assumption for medical and a 10% trend for pharmacy. Premium contributions assume a 1% annual increase in enrollment.

The 2018 Federal reinsurance true-up payment, and $1.2M in low-income cost sharing payments expected for January 2020 have been excluded for the purpose of the projections, but will be revised when received.

Total projected operating revenues are $943.0M. Total claims are projected at $909.0M. Holding rates flat resulted in a $6.3M loss of net income. The claim liability was updated to $58.5M based on claims experience through Q4. The minimum reserve of $24.3M did not change.

A MOTION was made by CG Morton and seconded by Ms. Anderson to approve the budget as presented.

MOTION ADOPTED UNANIMOUSLY

Updated GHIP Projections

The WTW budget of $837.0M reflects all operating expenses (net of rebates and EGWP payments not yet received), all program changes, the current GHIP enrollment as of July 2019, passed legislation, and copay changes.

Historically Q4 has the highest claims. However, for the second straight year the State GHIP has seen a decrease in Q4 medical claims. WTW will continue to monitor the trend. Overall the fiscal year ended favorably.

Secretary Johnson queried whether the savings from the program changes outweighed the costs of the approved legislation. Ms. Warnken confirmed.

2019 Open Enrollment increased membership by 1.6% over the FY19 average. FY20 enrollment projections assume a 1% growth during FY20, representing a .5% average increase over July 2019 and a 2.1% over FY19.

EGWP Funding Update

The EGWP program allows for the State to take advantage of Federal subsidy dollars, as well as pharmaceutical manufacturing dollars available previously only to the Medicare Part D Plans.

The direct subsidy is provided to any plan sponsor of a Medicare Part D pharmacy program. A decrease of $4.00 per member per month is expected for 2020. Additionally, the coverage gap discount payments is the portion of the payment paid by pharmaceutical manufactures for prescriptions that fall in the Medicare Part D gap. As more claims fall into the Medicare Part D gap, payments have been increasing year to year. The increase in coverage gap discounts offsets the loss in direct subsidy payments. The coverage gap discount payments are steady, but lag six months.

The federal reinsurance is a reimbursement by the federal government for claims above a catastrophic threshold based on the true out of pocket cost. As claims continue to rise above the threshold, the federal reinsurance amount will increase.

The timing of the cash flow has changed. The prospective method for reinsurance pays a fixed amount each month determined at the beginning of the calendar year. Reconciliation occurs at the end of the calendar year based on actual incurred reinsurance amounts. Payments are then adjusted and collected as a true-up. Some payments are incurring during the year in which they are attributable and some payments are happening 13 months after, and large sums paid out in January are attributable to a prior calendar year.

Long Term Projections

The FY19 GHIP ended with a surplus of $80.7M. Based on final FY20 projections, and no premium rate increase during the fiscal year, FY20 budget is projected to end with surplus of $74.7M. To smooth the FY20 surplus over 2 years requires a 1.2% premium increase for FY21.

A 2% increase in FY21 would result in a FY21 surplus of $43.9M. To hold premiums flat would result in a FY21 $27.1M surplus. No increases in premiums erodes the surplus in FY22 with a projected deficit of $65.9M.

A 2% increase reflects an employee contribution increase of $0.56 - $5.46 monthly and a State subsidy increase of $13.35 - $35.73 per employee per month.

Excise Tax Projection

In July, the House approved legislation to repeal the excise tax, but action from the Senate is pending. The GHIP is not projected to hit the excise tax until to 2023, with 2.5M projected liability with annual increases thereafter.

APPROACHES TO HEALTH CARE CONTRACTING – MS. JACLYN IGLESIAS, WTW

Payment reform aims to make a positive impact on patient care and health, including quality, patient engagement, and efficiency. Changing financial incentives is not enough to achieve patient-centered care, healthcare must also empower patients to be partners in their own care and to be more effective consumers. The value-based payment model has a collective impact on healthcare cost and quality by making the providers more accountable for the care they are delivering, and asking members to shop for healthcare in an informed way.

The US Department of Health and Human Services launched the Learning and Action Network (LAN), a public-private partnership to transition the healthcare system from a fee-for-service payment model to one that pays for quality care, improved health and lower costs. LAN established the Alternative Payment Model (APM) to provide a framework for providers and payers to work toward payment reform.

Contracted providers are either in-network or out-of-network (OON), and have different member cost share and contract terms. One exception is OON hospital-based physicians working in in-network hospitals. In this example, members may be utilizing an in-network site of care, and OON providers may balance bill excess of actual charges over plan reimbursement.

Sec. Johnson asked if the same contract terms would apply to concierge doctors. Ms. Iglesias responded that contracted PCPs are not precluded from charging a concierge fee.

Ms. Iglesias presented APM approaches to contracting. She noted that no one particular healthcare delivery model fits into only one category (e.g. Centers of Excellence and accountable care organizations are delivery systems that can be applied to and supported by a variety of payment models).

APM Category 1: Fee for Service – No Link to Quality & Value

Claims are paid for units of service provided. Payments are not adjusted for improvements to infrastructure (e.g. health information technology), reporting, or provider performance quality metrics designed to improve care delivery. FFS includes bundled payments that are not linked to quality and value. FFS demand-based interventions does not require the provider to manage services better.

APM Category 2 – Fee for Service – Link to Quality & Value

Claims are paid for units of service provided, but are adjusted (bonuses or penalties) for infrastructure investments, provider reporting, and provider performance quality metrics.

APM Category 3 – APMs Built on Fee for Service

Payments are the basis for provider compensation, but provides mechanisms to compensate providers for more effectively managing a set of procedures, or an episode of care, or all health services provided. In the 3A model, there is a shared savings to the provider for meeting goals, but providers do not have to pay payee back for not meeting goals. Alternately, in the 3B model, the provider can share in both the savings and losses. Category 3 promotes provider accountability for providing appropriate care and payments are retrospective.

APM Category 4 – Population-based Payments

Category 4 represents a system of providers responsible for managing patient care. Payments are prospective, population based, and structured to encourage providers to deliver well-coordinated care. Models of Category 4 may include bundled payments for a defined scope of practice, treatment of specific conditions, or care by particular types of clinicians. The most patient-centered approach and includes stronger incentive to promote health and wellness.

Sec. Johnson asked which category was the most expensive, and how concierge medical is categorized. Ms. Iglesias responded that while category 4 is the most robust, the returns are higher and without context it's difficult to say

which is the most expensive. She added that concierge medical would not fall into Category 2, 3, or 4, because there is no quality component.
Mr. Costantino stated that MD and VT moved to global budgets, requiring the provider to take on the risk of the population. He stated that global budgets based on hospital spend wasn't enough, and MD then moved to total cost of care. He noted a payment controversy occurred as a result of moving patients.

Global Referenced-Based Pricing
Philosophically different from value-based care, as there is no focus on the quality of care. Referenced-based pricing (RBP) involves capping payments to providers at a fixed price (e.g. set at a multiple of Medicare reimbursement rate). RBP introduces the potential for significant provider disruption and possibly balanced billing. Implementation requires a significant upfront investment of time and resources. Three states have explored or have implemented this strategy (MT, OR, & NC).

PUBLIC COMMENT
No public comment.

HIGHMARK DELAWARE REIMBURSEMENT STATEGY – MR. SEAN BURNS

Highmark designs plans footprint wide so that requirements are being met regardless of the state where the plan is located.

Highmark's approach to value-based care pays providers for high-quality outcomes to support healthier patients while managing costs, and supports providers in reducing waste and avoidable costs. Highmark aims to shift incentives away from volume to value. However, there are places where volume is incentivized - where they drive value. Incentives are aligned with providers. Preventive services are also being incentivized. Future FFS reimbursement will be impacted by value-based results.

The biggest challenge of reimbursement Category 4 is that proposed plan designs contradict existing programs. Incentives must be attainable and providers must have the resources to deliver on goals. Necessary analytics and infrastructure must be in place for physicians to access the information needed to manage the population.

Physicians are trying to navigate the plan. Highmark is working to build relationships and support providers moving to a more advanced risk value-based-pricing glide path. Highmark communicates profile measures prior to scoring providers. Additionally, metrics are aligned to national standards to reduce provider confusion and limit reporting burden.

Highmark has piloted new payment models to advanced reporting capabilities that providers can leverage to improve care delivery. True Performance Analytical Suites provides reporting on quality, costs and utilizations. Program consultation includes Clinical Transformation Consultants and a Provider Support Analytical Team to assist providers with insights and analytics.

Highmark presented 2018 True Performance outcomes. Overall there are approximately 1.9M attributed members. Within Delaware there are more than 240K members, 125 practices and 79 entities.

Mr. Costantino asked how patient attribution was measured. Mr. Burns responded a PCP relationship is tracked by claims data. Additionally, a Customer Alignment Team outreaches to members to encourage engagement with a PCP.

Highmark reported the PCP trends relative to the Delaware geography have increased year over year from 2016 to 2018, from 981 in the beginning of 2016 to 1402 at the end of 2018. Highmark continues to focus on growing the PCP network.

Dir. Rentz asked what percent of the physicians are in the True Performance. Mr. Burns responded that True Performance doesn't represent all delivery systems (e.g. Christiana and Nemours are in a custom program). He stated that there are 123 practices, with typically between 2-10 physicians, but larger delivery systems are also included (e.g. Beebe counts as 1).

OTHER BUSINESS
No new business.

EXECUTIVE SESSION
A MOTION was made by Ms. Steward and seconded by Mr. Costantino to move into Executive Session at 3:52 p.m. for presentation on Value Based Contracting with Highmark Delaware.
MOTION ADOPTED UNANIMOUSLY

CALLED TO ORDER
Director Rentz called the meeting back to order at 4:41 p.m.

ADJOURNMENT
A MOTION was made by Secretary Johnson and seconded by CG Morton to adjourn the meeting at 4:42 p.m.
MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

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Martha Sturtevant, Statewide Benefits Office, Department of Human Resources
Recorder, Statewide Employee Benefits Committee