MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
DECEMBER 16, 2019

The State Employee Benefits Committee (the "Committee") held a meeting on December 16, 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:
Director Michael Jackson, Office of Management & Budget ("OMB"), Co-Chair
Secretary Saundra Johnson, Department of Human Resources ("DHR"), Co-Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer ("OST")
The Honorable Bethany Hall-Long, Lieutenant Governor
The Honorable Trinidad Navarro, Insurance Commissioner Department of Insurance ("DOI")
Secretary Kara Walker, Department of Health and Social Services ("DHSS")
Controller General Mike Morton, Office of the Controller General ("CGO")
Ms. Judy Anderson, Delaware State Education Association ("DSEA") (Designee of Jeff Taschner)
Ms. Ashley Tucker, Staff Attorney, Administrative Office of the Courts (Designee OBO Chief Justice Collins Seitz)

Others in Attendance:
Director Faith Rentz, Statewide Benefits Office ("SBO"), DHR
Deputy Director Leighann Hinkle, SBO, DHR
Deputy Attorney General, Andrew Kerber, Dept. of Justice, SEBC Legal Counsel
Mr. Kevin Fyock, Willis Towers Watson ("WTW")
Mr. Chris Giovannello, WTW
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Ms. Victoria Brennan, Sr. Legislative Analyst, CGO
Mr. Bob Byrd, The Byrd Group
Ms. Julie Caynor, Aetna
Ms. Cherie Dodge Biron, Controller, DHR
Ms. Judy Grant, Health Advocate
Ms. Tina Hession, PHRST
Ms. Heather Johnson, Accountant, DHR
Ms. Molly Magarik, Deputy Secretary, DHSS
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walt Mateja, IBM Watson Health
Ms. Danielle Millman, Administrative Accountant, DHR
Ms. Emily Molinaro, Fiscal & Policy Analyst, OMB
Ms. Jennifer Mossman, Highmark Delaware
Mr. Mike North, Aetna
Mr. Tanner Polce, Policy Advisor, Lt. Gov.
Dr. George Schreppler, DE Chiropractic Services Network
Ms. Judi Schock, Deputy Principal Assistant, OMB
Mr. Stuart Snyder, Chief of Staff, DHSS
Ms. Martha Sturtevant, Executive Assistant, SBO, DHR
Mr. Jabari Wells, Accountant, DHR
Ms. Meg Williams, Delaware Healthcare Association

CALL TO ORDER
Director Jackson called the meeting to order at 2:00 p.m. and introductions were made.

APPROVAL OF MINUTES – DIRECTOR JACKSON
A MOTION was made by CG Morton and seconded by Secretary Johnson to approve the minutes from November 18, 2019 State Employee Benefits Committee meeting.
MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ
Subcommittee Updates
Both Subcommittees met on December 7, 2019. The Financial Subcommittee reviewed the materials being presented to the Committee for discussion.

The Health Policy & Planning Subcommittee continued discussions on primary care specifically reviewing the 2017 State of Delaware onsite clinic Request for information and resulting decisions made by the Committee. The Committee requested vendors to present on enhanced telehealth and employer sponsored primary care models. The Subcommittee has invited Cerner and American Well to present in January.

Current Requests for Proposals

The Request for Proposal ("RFP") for Supplemental Benefits has been completed and a recommendation is on the agenda for discussion.

The RFP for Fertility Benefits Administration has been completed and final recommendations are being prepared to present to the Health Policy & Planning Subcommittee for further discussion in early CY20.

The Employee Assistance Program RFP is scheduled to be advertised on January 6, 2020.

SurgeryPlus

SurgeryPlus has 233 open cases through November 30, 2019; 25 surgeries have been completed.

Flexible Spending Account Open Enrollment – November 1 – 15

Enrollment for Flexible Spending Accounts ("FSA") was open from November 1 to November 15, 2019. Final CY20 counts include 5,210 members enrolled in a Health Care FSA, and 703 members enrolled in a Dependent Care FSA. There was a 13% decrease in FSA enrollments over CY19. A decline in enrollment was expected as a result of the short plan year.

FINANCIALS – WTW

October Fund Report- Mr. Chris Giovannello

Additional revenue has posted from a late premium collection from September reflecting higher than projected premium contributions. Other Revenues reflect a performance guarantee payment from ESI of $295K. Claims remain over budget attributable to trend assumptions and driven by pharmacy claims being over budget. Medical claims remain under budget. The fund is running 1.13% or $3.4M above budget in claims through October. October has a negative net income of $6.8M, for a YTD deficit of $11.1M or a negative $3.75M variance to budget.

Plan Migration Analysis- Rebecca Warnken

The Committee reviewed key findings of the Plan Migration Analysis.

There was a 22.3% engagement with the myBenefitsMentor tool. Of those who used the tool, 12.2% enrolled in the lowest cost option, compared to 8.9% of those who did not use the tool. The highest enrollment continues to be in the Highmark PPO ("PPO") plan, with 56% of members who used the tool still enrolling in highest cost plan.

Approximately 10% of Highmark's First State Basic ("FSB") members migrated to the PPO, but it was noted that these members had higher costs on average in FY19 which may have led to the change in enrollment.

Approximately 6% of Aetna HMO ("HMO") members migrated to the PPO. It was noted that those members had comparable costs and the plan change was not the result of higher costs.

Consistent with trends in prior years the PPO continues to attract members with the highest average risk scores.

The State is limited in its ability to steer members to lower cost plans without legislative changes to the subsidy structure of plan design, however there is an opportunity to develop communications and incentive strategies to encourage use of myBenefitsMentor tool.

GHIP members continue to favor comprehensive coverage with higher payroll deductions. 44% of PPO families had allowed costs under $5K, indicating a willingness to pay higher premiums with potentially higher out-of-pocket costs. Alternatively, approximately 20% of FSB and CDH members had allowed costs over $10K, indicating a willingness to pay less in payroll contributions for potentially higher out-of-pocket expenses.

For 49% of the plan population, Aetna CDH ("CDH") was the lowest cost plan recommended for FY20, followed by HMO at 21.8%, and FSB at 29.2%. This compares to actual enrollment of 56% in PPO, 4.8% in CDH, 20.5% in HMO, and 5.2% in FSB.

Members who elected the CDH Plan had the highest engagement rate, with 40% using the tool. This compares to 22% of PPO members that used the tool. The CDH Plan also had the highest take up rate with 10% of members who used the tool choosing the recommended plan, compared to 4% of CDH members who did not use the tool.

Sec Johnson expressed concern that 56% of the GHIP enrolled in the highest cost plan even though the PPO plan was not recommended. She queried whether demographics played a role in plan selection. Ms. Warnken responded that the reporting reflects that older, high-risk members are more likely to choose a PPO plan.

There was a slight shift in enrollment out of HMO into the PPO from FY19 to FY20.

Plan demographics remained consistent. Families are more likely to enroll in the HMO or PPO Plans, and FSB has the highest enrollment of single coverage. PPO has the highest average age (35yrs) and highest risk score (149.4), and CDH has the lowest age (33yrs) and lowest risk score (109.7).

HMO participants who migrated to PPO saw little difference in the PMPM cost, compared to FSB participants who migrated to PPO and increased $27 PMPM.

FSB had the highest utilization of emergency room ("ER") visits and may represent members that prefer a plan with the lowest payroll deduction over plans that encourage the use of alternate sites-of-care.

PPO has the highest office visits and highest hospital admits per 1000 as well as the highest days supply of prescriptions, representative of the higher average risk score.

GHIP plans generally outperform the benchmark in preventative screenings. FSB has the lowest preventative visits per 1000, and the lowest compliance in preventative services and may indicate a younger, healthier demographic that does not feel the need for regular checkups and screenings. The PPO plan generally has the highest compliance in preventative screenings. CDH had the highest number of well visits per 1000, followed closely by PPO.

Secretary Walker expressed concern that only 4% of employees that used the tool migrated to the recommended plan. She queried alternative levers that would improve engagement (e.g. a more significant premium differential, requiring participation, or defaulting members into the recommended plan). Mr. Fyock responded that the tool is a separate step from enrollment, and he suggested that better connectivity would improve participation.

Lt. Gov. Hall-Long arrived.

Secretary Johnson queried whether 100% participation in the use of the myBenefitsMentor tool would result in the same plan elections. After employee education, she queried the primary goal. Mr. Fyock responded that some employees will always be over or under insured but should have tools to make an informed choice across a suite of offerings. He added that budget neutrality so that premium differential is commiserate with the value differential in the plans can be beneficial.

GHIP Impact Analysis – Mr. Chris Giovannello

The Committee reviewed the results of initiatives, site-of-care steerage plan design changes, and clinical management program changes on the GHIP based on FY19 incurred experience.

From FY17 to FY19 the utilization of ER for non-emergent care increased slightly, while urgent care utilization increased 14%. There was appropriate steerage from ER care for non-emergent conditions, however urgent care may be overutilized for conditions that could be treated in a primary care setting.

Utilization of hospital-based basic imaging facilities decreased slightly in FY19, while freestanding imaging increased 8%. Results indicate that FY19 plan design changes were effective in steering care to freestanding facilities. It is recommended to communicate copay differentials in years where there are no plan design changes to encourage utilization of the preferred sites-of-care.

Treasurer Davis queried if costs for imaging at hospital-based facilities increased as a result of copay changes. Mr. Giovannello did not have the specific cost-per-service data available but steady increases applied across all sites-of-care for imaging services. WTW will follow up.

Secretary Johnson queried why steerage resulting from copay differentials isn't consistent. Members discussed that members may not remember the cost differential for different sites-of-care, and that urgent care facilities are not open after hours. Members queried whether data was available regarding the time of day services were utilized. Mr. Fyock responded that claims cannot be evaluated based on time of service. Members discussed that an exit survey would be helpful, and whether an increased differential or ongoing SBO communication is most effective.

FY18 to FY19 plan design changes were effective in steering site-of-care for outpatient lab services. Preferred lab utilization increased 6%, while hospital utilization for lab services decreased slightly. The FY20 copay differential is expected to continue the trend, but ongoing communications are recommended.

The estimated site-of-care steerage savings built into the FY19 budget projections based on estimates provided by Highmark & Aetna were $1.3M. Actual savings realized in FY19 for utilization of these services is estimated at $660K.

Members discussed that one more year of data including FY20 copay differentials will help forecast future savings.

Members queried how claims data could be dissected to better identify populations with the highest use of preferred sites-of-care. Ms. Warnken cautioned against analyzing small sample sizes that do not compare the same people year over year. WTW will consider whether the data can be viewed differently to identify best practice users.

Members discussed messaging. SBO communications alone may not be enough to educate members and queried other delivery technologies that could be leveraged to better educate members on cost differentials and promote preferred sites-of-care. Messaging should communicate a shared success story so that employees understand why the choices they make matter. Reminders sent outside of Open Enrollment will encourage site-of-care steerage throughout the year.

Other interventions to promote site-of-care steerage include the Aetna program for infusion therapy. The program administers intravenous medications that treat conditions such as autoimmune disorders, enzyme replacement or rare/esoteric diseases. Alternate sites-of-care include infusion centers, doctor's office or patient's home. Aetna reviews request and will reach out to doctor to suggest alternate site-of-care if appropriate. The projected savings for calendar year 2019 is $503K.

GHIP Impact Analysis of Clinical Management Programs – Ms. Jaclyn Iglesias

The Committee reviewed several enhanced care management programs offered by the GHIP and the impact on the health of the GHIP population from FY17 to FY19.

Three programs are designed to target acutely or chronically ill members: CareVio (formerly Carelink CareNow), case and disease management, and Custom Care Management Unit ("CCMU"). Other condition specific programs focus on diabetes and metabolic syndrome.

The PPO Plan has the highest risk scores, and the CDH and HMO Plans also had significant increases in FY19 attributable to High Cost Claimants ("HCC"). The total cost associated with HCC increased from 22% to 25% of net payments attributable to HCCs, and the cost per HCC has been trending higher and with more variability compared to non-HCCs.

Members discussed a 15.5% increase in net paid PMPM for HCCs from FY17 to FY18. WTW responded that in FY18 there were a number of outlier high cost claims, and that the HCC threshold is $100K and can be easily reached with a hospital stay.

Top clinical cost drivers include newborns with and without complications, cancer (breast leukemia & lung) and coronary artery disease. Other top HCC conditions include pregnancy related services, spinal and back disorders, respiratory disorders, and diabetes. Cancers were the most frequently reoccurring clinical condition in HCC by plans and across multiple plan years.

Preventive care can aid in early detection of certain cancers and chronic conditions that lead to HCC. Screening rates for cervical and colon cancer improved across all plans from FY18 to FY19, however breast cancer screenings decreased over the same period and across all plans.

Well child visits were consistent, but there is opportunity for improvement as well as to improve adult well visits across all plans.

The Committee reviewed the prevalence of chronic disease across the GHIP population. Prevalence of chronic diseases is higher in the GHIP for both actives and non-Medicare pensioners when compared to the IBM Watson book of business average.

Diabetes was the highest cost clinical condition with the most expensive episode of care. There is good compliance across the diabetic population of the GHIP, however ongoing education is recommended.

Ongoing member education is recommended regarding alternative sites-of-care and promoting preventive care/screening compliance and management of chronic conditions across all plans. There is an opportunity to explore services and programs that support members in the top condition/cost categories, and to incorporate changes into the upcoming medical TPA contract renewals as it relates to member engagement, education, utilization and cost of programs and/or providers.

Lt. Gov Hall-Long requested that mental health screenings be added to the preventative screening metrics. Ms. Iglesias will research available data to incorporate into the report.

SUPPLEMENTAL BENEFITS REQUEST FOR PROPOSAL AWARD RECOMMENDATION

A Request for Proposal ("RFP") has been completed and a recommendation has been made to procure a Group Accident and Critical Illness (with cancer coverage) supplemental insurance carrier to serve approximately 33K eligible employees and 44K dependents. This benefit is offered as required by House Bill 336. AFLAC is the incumbent vendor.

This supplemental insurance is offered to employees of the State of Delaware, the University of Delaware, school districts, charter schools, and other higher education institutions and their dependents, and is an employee-pay-all benefit.

10 insurance companies submitted an intent to bid, 3 submitted a proposal. Reasons given for declining to bid include the claim loss ratio requirements, administrative requirements, historically low enrollment, unwillingness to guarantee performance, and an inability to meet requirement for State's right to audit.

During the bid process, Voya withdrew their bid due to a difference in its preferred approach to administer the benefit. Two finalists were interviewed. The Proposal Review Committee ("PRC") voted to recommend a contract award to Securian.

The Proposal Review Committee (PRC) scored Securian higher than Allstate. As a current administrator for the State's Group Universal Life, Securian has existing administrative synergies with the State. They offered comparable coverage to the incumbent with significantly lower premiums and a five year rate guarantee.

A MOTION was made by Secretary Johnson and seconded by CG Morton to approve the recommendations of the Proposal Review Committee to award the contract for State Group Accident and Critical Illness supplemental insurance to Securian for an initial three-year term effective July 1, 2020 through June 30, 2023 with two optional one-year period extensions.
MOTION ADOPTED UNANIMOUSLY

OTHER BUSINESS
No new business.

PUBLIC COMMENT
No public comment.

EXECUTIVE SESSION
A MOTION was made by CG Morton and seconded by Secretary Walker to move into Executive Session at 3:15 p.m. to discuss healthcare contracting.
MOTION ADOPTED UNANIMOUSLY

Controller General Mike Morton exited the meeting prior to Executive Session.
Dir. Jackson and Lt. Gov Hall-Long exited Executive Session at 4:15 p.m.

CALL TO ORDER
Director Rentz called the public meeting back to order at 4:40 p.m.

ADJOURNMENT
A MOTION was made by Secretary Johnson and seconded by Secretary Walker to adjourn the meeting at 4:40 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