MINUTES FROM THE HEALTH POLICY & PLANNING SUBCOMMITTEE
TO THE STATE EMPLOYEE BENEFITS COMMITTEE
JUNE 6, 2019

A meeting of the Health Policy & Planning ("HP&P") Subcommittee to the State Employee Benefits Committee (the "Committee") was held Thursday, June 6, 2019 in the Large Conference Room of the Statewide Benefits Office ("SBO"), 97 Commerce Way, Dover, Delaware 19904

Committee Members Represented or in Attendance:
Director Faith Rentz, SBO, Department of Human Resources ("DHR") (Appointee of DHR Sec. Johnson), Chair
Mr. Steve Costantino, Dir. of Health Care Reform, Department of Health and Social Services ("DHSS") (Appointee of Sec. Walker)
Ms. Judi Schock, Deputy Principal Assistant, Office of Management & Budget ("OMB") (Appointee OMB Dir. Jackson)
Mr. Stuart Snyder, Chief of Staff, Department of Insurance ("DOI") (Appointee of Commissioner Navarro)
Ms. Susan Steward, Policy Analyst, Office of the State Treasurer ("OST") (Appointee of Treasurer Davis)
Mr. William Oberle, Delaware State Trooper's Association (Appointee of the DSEA, Jeff Taschner)

Committee Members Not Represented or in Attendance:
Ms. Victoria Brennan, Sr. Legislative Analyst, Office of the Controller General ("OCG") (Appointee for CG Morton)
Mr. Tanner Polce, Policy Director, Office of the Lt. Governor (Appointee of Lt. Governor Hall-Long)

Others in Attendance:
Deputy Director Leighann Hinkle, SBO, DHR
Ms. Jaclyn Iglesias, Willis Towers Watson ("WTW")
Mr. Chris Giovannello, WTW
Ms. Nina Figueroa, Policy Advisor, SBO, DHR
Ms. Katherine Impellizzeri, Aetna
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walter Mateja, IBM Watson Health
Ms. Jennifer Mossman, Highmark Delaware
Ms. Martha Sturtevant, Executive Assistant, SBO, DHR

CALLED TO ORDER
Dir. Rentz called the meeting to order at 1:03 p.m.

APPROVAL OF MINUTES – DIRECTOR RENTZ
A MOTION was made by Ms. Steward and seconded by Ms. Schock to approve the minutes from the May 2, 2019 Health Policy & Planning Subcommittee meeting.
MOTION ADOPTED UNANIMOUSLY.

DIRECTOR'S REPORT – DIRECTOR RENTZ
SEBC Update
The Committee will meet June 10, 2019 and is expected to vote on several proposals. The Committee will consider whether to increase health care premiums in FY20, and vote on the recommendations to enhance Group Health Insurance Program ("GHIP") infertility benefits. Dir. Jackson will provide the Committee with an update from the Joint Finance Committee regarding the availability of funding for both proposals.

The Committee is also expected to consider the contract award recommendation of the Proposal Review Committee for the renewal of the Flexible Spending, Pre-tax Commuter, and Consolidated Omnibus Budget Reconciliation Act ("COBRA") Request for Proposal. The effective date for the contract as proposed will be January 1, 2020.

Subsequent to today's Subcommittee meetings, the Committee will consider and is expected to vote on the final recommendations to the plan design and incentive proposal for SurgeryPlus.

Finally, the Committee is expected to discuss, but not yet vote on, the adoption and implementation of a Health Savings Account ("HSA") plan.

Financial Subcommittee

The Financial Subcommittee met the morning of June 6, 2019 to finalize recommendations for the proposed Health Savings Account ("HSA") implementation.

Mr. Oberle stated that upon reviewing the meeting minutes for the Financial Subcommittee, he noted an overlap of topics and proposed meeting jointly more often. Noting upcoming FY20 focus items for consideration, Dir. Rentz responded that more joint meetings of the Subcommittees are likely. Dir. Rentz distributed a list of proposed focus items for consideration and discussion in the second half of 2019.

Updates/Handouts

A copy of SB 116 was distributed. The Bill would modify the makeup of the Primary Care Collaborative to expand the collaborative to include SEBC representation. It would also create the Office of Value Based Healthcare. The Department of Insurance would staff and support the creation of the new office. SBO, with Highmark and Aetna, is actively monitoring the trend of primary care doctors moving toward a MDVIP concierge model of care. While the MDVIP model does not preclude the physician from participating in the Aetna or Highmark networks, its focus is primarily on concierge patients, and may limit access to GHIP members. The Subcommittee will meet in August and there will be further discussion on the outcome of SB 116.

The Express Scripts contact renewal is complete. The Highmark amendment is expected to be finalized within the week. Additionally, Aetna amendments are expected to be completed by the end of June. SBO remains in ongoing discussions with all three vendors regarding Value Based Contracting, monitoring network access and utilization, performance guarantees and metrics for preventative care, diabetes prevention and management programs, program enhancements, and monitoring of mental health/behavioral health benefits.

Mr. Oberle queried whether contract negotiations with Highmark included conversations on increased transparency. Dir. Rentz responded that SBO remains in ongoing discussions with the vendors regarding value based contracting initiatives, cost transparency, care management and outcomes data.

Mr. Costantino inquired about the results of Open Enrollment ("OE") and utilization of myBenefitsMentor. Dir. Rentz responded that final reporting is expected mid-June, but added that preliminary results appear consistent with 2018. Statistics on active engagement and participation in the OE Highlights video will be shared the first week of July, but a migration analysis will not be available until September. There was approximately a 20% participation in myBenefitsMentor.

Mr. Oberle thanked Dir. Rentz for working with the Delaware State Police regarding the additional verification process for Double State Share participants. Dir. Rentz responded that the feedback was helpful.

HEALTH SAVINGS ACCOUNT RECOMMENDATIONS – MS. JACLYN IGLESIAS & MR. CHRIS GIOVANNELLO, WTW

The PRC recommended the Subcommittees evaluate the overall GHIP plan offerings and consider a Health Savings Account ("HSA") plan. Final recommendations will be presented to the Committee on Monday, June 10, 2019.

Members reviewed proposed plan design scenarios. Responses received by three out of five Subcommittee members favored Scenario 1, and two out of five preferred Scenario 2; the difference being the Relative Benefit Value of 0.89 and 0.93, respectively.

Prescription coverage in a HSA plan differs from the CDH Gold Plan in that prescription cost sharing applies only after the deductible has been met. Therefore, the Subcommittees agree any adoption of a HSA plan must be in conjunction with a rigorous communication campaign.

Subcommittee respondents surveyed were unanimous in their recommendation that seed funding be deposited as an upfront lump sum, and prorated by quarter for new hires.

Members reviewed the potential financial impact of offering a HSA. Offering a HSA does not create meaningful savings for the State, but rather adds choice for members. Per every 5% of member migration from all plans to the HSA plan, there would be $2.9M in savings with $1.9M to the General Fund under scenario 1, and less under scenarios 2 & 3.

Mr. Snyder disagreed that offering a HSA as proposed creates choice, because it eliminates the CDH Gold Plan.

Per Delaware Code, the State is required to pay 95% of the premium for a consumer-directed health care plan. WTW recommends setting the HSA budget rate based on the plan design value relative to CDH Gold, and setting the employee contributions equal to 5% of the budget rate.

Members considered the impact to other GHIP plans. If a HSA plan is to be implemented, WTW recommends retaining the CDH Gold Plan for existing enrollees only, but discontinuing future HRA funding. Subcommittee respondents agreed 4 to 1 to freeze the existing CDH Gold Plan.

It is recommended that the State delegate oversite of HSA investment options to the HSA administrator and/or banking partner. Subcommittee respondents were unanimously in favor of this recommendation.

Members reviewed the proposal for member education and communications. The timeline proposed for implementation is a minimum of 12 months.

Members discussed the bandwidth of SBO to effectively support the proposed implementation. Dir. Rentz responded that the Committee will evaluate the HSA proposal in consideration of other FY20 goals. SBO would benefit from additional support.

Mr. Snyder expressed his opposition to a HSA plan option, stating that the mission of the Committee is to efficiently maintain and preserve GHIP benefits. He stated that a migration to a HSA does not effectively reduce costs for the State or the member, but reduces the benefit when compared to a CDH Gold Plan. He expressed concern that a HSA eliminates the cost sharing prescription program members are familiar with (until after the $2K/$4K deductible has been met). Mr. Snyder added that the low utilization of benefit tools exposes the challenge of effective communications, and many employees will be unprepared for this additional expense.

Mr. Oberle agreed that a HSA reduces benefits and choice. He noted the added administration of the plan and queried whether the demographics were applicable within State government. Ms. Iglesias responded that a HSA can be an attractive benefit, and recruiting tool, but agreed it will not be the best plan for all members.

Members acknowledged that millennials interact differently with heath care, and the HSA option may offer a more attractive choice for new employees. Mr. Snyder replied that salary, not benefits, is the largest decision making factor.

Members discussed a potential cost benefit analysis, the member impact of an unfavorable experience, and the unintended impact to other SEBC initiatives if a HSA is implemented without additional resources and SBO support.

Members discussed the potential for a HSA to migrate members in the wrong direction, and whether necessary communication is too difficult.

Mr. Costantino inquired how many states have a HSA option. Ms. Iglesias responded that 26 states have added a HSA. Mr. Costantino asked Ms. Iglesias to determine if other states had ever removed the HSA option, and how they were able to limit members from choosing the wrong plan.

Members discussed that a lower cost option may appeal to Millennials who may otherwise decline coverage.

PHRST is ready to implement HSA contributions via payroll deductions with an effective date no earlier than July 1, 2020. There are participating groups with varying payroll systems that would prevent employees from making pre-tax payroll deductions. Employees without payroll deductions could still realize the pre-tax benefit by initially making HSA contributions on a post-tax basis and then making an adjustment on their personal tax filing.

SURGERYPLUS IMPLEMENTATION – MS. JACLYN IGLESIAS & MR. CHRIS GIOVANNELLO, WTW

A Center of Excellence ("COE") is a medical facility and/or professional that has been identified as delivering high quality services and superior outcomes for specific procedures or conditions.

Access to COEs are available through Highmark and Aetna for a limited scope of services. Some travel provisions are provided and members pay out-of-pocket expenses according to their plan.

A RFP was issued in March 2018 to evaluate third-party administrators of COE services to reduce the total cost of care, provide members with access to providers providing a higher quality of service while minimizing disruption to members going outside of their plan, and to incentivize providers who deliver higher quality care at a lower cost. The PRC recommended SurgeryPlus, and the Committee voted to adopt the recommendation on October 22, 2018.

SurgeryPlus includes an increase in the breadth of types of procedures currently available. While the SurgeryPlus network is primarily outside of Delaware (Philadelphia, New Jersey and Baltimore/Greater DC areas), they have placed patients with Delaware providers in bariatrics and orthopedics under single case agreements, and are committed to adding to their Delaware network through a stringent Physician and Facility credentialing process.

Mr. Oberle queried if there was a third party review of the credentialing process. Dir. Rentz responded that the contract will be finalized by the end of June, and can incorporate ability to audit.

Travel concierge benefits are robust with SurgeryPlus, including per diem and companion travel. Member out-of-pocket expenses will be waived, and the proposed incentive design provides members with an incentive of $500 to $4K, which varies based on the extensiveness of procedure. Additionally, the tax reporting would be handled by SurgeryPlus.

Members who chose to participate in the program will be assigned a Care Advocate to guide them through process. If the member has a surgeon in mind, the Advocate will work to evaluate and approve, or make an alternate recommendation. Support will be provided for travel arrangements, transfer of medical records, scheduling consults, testing, surgical procedure and follow-up.

Financial projections include a savings of $0.5M. A revised estimate based on the expanded list of procedures and tiered incentive design, and GHIP claim data suggests a savings of $2.7M based on a 10% average first-year utilization.

Eligibility files are being established so that SurgeryPlus may proactively outreach to members who have been identified as possible candidates based on claims data.

Financial subcommittee members are in favor of the plan design in conjunction with a strong member communication, ongoing monitoring of utilization and regularly revised savings estimates.

Member communications are posted on the SBO website, and SurgeryPlus was present during all health and education fairs and Benefits Representative meetings. SBO will work with SurgeryPlus to provide all benefit eligible employees with an ID card and welcome letter.

Pre-op and post-op testing, and rehab is outside of the bundled rate. However, admission through discharge, all surgeon, anesthesia, and facility related fees, and any follow-up appointments during the Medicare global time period for that procedure, are included in the single episode of care.

If the Committee adopts a HSA, there is flexibility in the plan design to address the additional compliance considerations.

OTHER BUSINESS

Mr. Oberle asked to include the prohibition of balanced billing as it relates to referenced based pricing, and the Certificate of Need process to the list of FY20 items for discussion.

ADJOURNMENT

A MOTION was made by Mr. Snyder and seconded by Mr. Oberle to adjourn the meeting 2:39 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