MINUTES FROM THE MEETING OF THE COMBINED SUBCOMMITTEES TO THE STATE EMPLOYEE BENEFITS COMMITTEE SEPTEMBER 19, 2019

A meeting of the Combined Subcommittee to the State Employee Benefits Committee (the "Committee") was held Thursday, September 19, 2019 in the Large Conference Room of the Statewide Benefits Office ("SBO"), 97 Commerce Way, Dover, Delaware 19904

Subcommittee Members in Attendance:
Director Faith Rentz, SBO, Department of Human Resources ("DHR") (Appointee of DHR Sec. Johnson), Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer (OST)
Ms. Judy Anderson, Delaware State Education Association ("DESA") (Appointee of Jeff Taschner)
Ms. Victoria Brennan, Sr. Legislative Analyst, Office of the Controller General ("OCG") (Appointee for CG Morton)
Mr. Steve Costantino, Dir. of Health Care Reform, Dept. of Health and Social Services ("DHSS") (Appointee of Sec. Walker)
Ms. Ruth Ann Jones, Office of the Controller General ("OCG") (Appointee for CG Morton)
Mr. William Oberle, Delaware State Trooper's Association (Appointee of the DSEA, Jeff Taschner)
Mr. Tanner Polce, Policy Director, Office of the Lt. Governor (Appointee of Lt. Governor Hall-Long)
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. Emily Thomas, Fiscal and Policy Analyst, OMB

Others in Attendance:
Mr. Jeff Taschner, DSEA, Committee Member
Deputy Director Leighann Hinkle, SBO, DHR
Mr. Kevin Fyock, Willis Towers Watson ("WTW")
Mr. Chris Giovannello, WTW
Ms. Rebecca Warnken, WTW
Ms. Cherie Biron Dodge, Controller, DHR
Ms. Julie Caynor, Aetna
Ms. Nina Figueroa, Policy Advisor, SBO, DHR
Mr. Bryan Gordon, CCHS
Mr. Walter Mateja, IBM Watson Health
Ms. Lisa Mantegna, Highmark Delaware
Ms. Mary Kate McLaughlin, Drinker Biddle
Ms. Jennifer Mossman, Highmark Delaware
Ms. Martha Sturtevant, Executive Assistant, SBO, DHR
Ms. Elizabeth Zubaca, Hamilton Goodman Partners
Mr. Wayne Smith, Delaware Healthcare Association
Mr. Lincoln Willis, The Willis Group

CALLED TO ORDER
Dir. Rentz called the meeting to order at 10:03 a.m.

A draft of the 2020 SEBC Subcommittee schedule was distributed. It was noted that due to the timing of available financial information, the Financial Subcommittee may not meet each month, and that when appropriate the Subcommittees would meet in a combined session. Combined Subcommittee meetings will be communicated in advance as necessary.

APPROVAL OF MINUTES – DIRECTOR RENTZ
A MOTION was made by Treasurer Davis and seconded by Ms. Jones to approve the minutes from the August 22, 2019 Financial Subcommittee meeting.
MOTION ADOPTED UNANIMOUSLY.

A MOTION was made by Mr. Snyder and seconded by Ms. Brennan to approve the minutes from the August 22, 2019 Health Policy & Planning Subcommittee meeting.

MOTION ADOPTED UNANIMOUSLY.

DIRECTOR'S REPORT – DIRECTOR RENTZ, CHAIR

Audits

SBO has completed the FY17 and FY18 audit of the medical and prescription plans. There were no significant findings. SBO is working with Highmark and Aetna to incorporate several recommendations into the Summary Plan Document to clarify coverage. The prescription audit included an audit of manufacturer rebates paid to the plan with no findings or areas of concern. Recommendations were made to improve transparency in contracting provisions.

Articles

Included in meeting materials are two articles. An article from Kaiser Health News illustrates the frustration from consumers regarding pricing and unexpected out-of-pocket costs. Additionally, the Delaware Healthcare Association published an article in the News Journal regarding the efforts underway to address primary care access in Delaware.

PCP Access

A summary of Aetna and Highmark Primary Care Providers ("PCP") was distributed. SBO will continue to provide quarterly updates to the Health Policy & Planning Subcommittee.

PCP Survey

The PCP Access Survey closed on September 16, 2019 with approximately 9% of employees responding to the survey. HP&P members will review the results and continue the discussion at the October 10, 2019 Subcommittee meeting.

Certificate of Need ("CON") Process/Sunset Committee

The Delaware Health Resources Board was notified at the August meeting that the Joint Legislative Oversight and Sunset Committee ("JLOSC") voted in June to conduct a comprehensive review of the Board. JLOSC staff are preparing a performance review questionnaire and have asked for feedback from Board members by October 16th. Section II of the questionnaire asks for the justification and need for existence. SBO and DHSS are preparing a response. Members may submit comments directly to Ms. Hinkle for incorporation though October 4, 2019.

Mr. Polce arrived.

SEBC

The Committee will meet September 23, 2019 to review the July Fund Report, and the Securian Life Insurance Renewal recommendations with request for vote. If approved, the Securian contract would continue through June 30, 2025. Recommendations propose no change in active employee rates, and a one-time 5% increase for the retired/ported group effective July 1, 2020. Additionally, there will be a continued discussion of health care contracting with a presentation by Aetna in both Public and Executive Session.

FINANCIALS – MR. GIOVANNELLO, WTW

Other Revenues in the July Fund Report include a Federal Reinsurance prospective payment. The Centers for Medicare & Medicaid Services ("CMS") reconciles periodically to make adjustments to the payment amount based on plan performance. Per member per month rates are expected to increase.

The Coverage Gap Discount Payment of $2.9M is for claims incurred Q1 of 2019, while the budget is adjusted for anticipated claims in Q3 of 2019.

Claims ran $2M above budget in July, primarily in pharmacy expenses; commercial pharmacy claims were $1.4M above budget, and EGWP claims were $0.96M above budget. Claims experience for the quarter is higher than 2018, and will be monitored for trend. There was an overall net income loss of $19.0M compared to $13.5M expected for a variance to budget of $5.4M, bringing the Fund Equity balance to $144.8M. Ms. Warnken added that a negative net income for the end of the year is expected as a result of no rate increase.

Members inquired about several program expenses, including consultant fees that were over budget for July. Ms. Warnken noted that the variance was not significant, but added that it is a result of fiscal year startup expenses. Ms. Biron-Dodge, DHR Controller, confirmed that the payments were higher in July as a result of two ASO fees paid for June and July. Dir. Rentz will confirm.

APPROACHES TO HEALTH CARE CONTRACTING – MR. FYOCK, WTW

Members reviewed the Group Health Insurance Plan ("GHIP") framework and the Alternative Payment Model ("APM") framework. The APM framework works to move payments from fee-for-service to pay-for-value, and provide more clarity to the term, "value-based-care".

There are four APM categories: Category 1, 2, 3 and 4. Category 1 has no link to quality and value, to Category 4 that has a population based payment model. Moving from Category 1 to 4 lowers the total cost of care, and increases the quality of care.

Mr. Costantino expressed that it is misleading that LAN Category 4 description drops the term, "fee-for-service."

Centers of Excellence ("COE"), Accountable Care Organizations, and Patient-Centered Medical Homes are examples, rather than Categories, in the APM Framework, because they are delivery systems that can be applied to and supported by a variety of payment models.

Mr. Oberle requested clarification when comparing COE like SurgeryPlus and COEs within Delaware. Mr. Fyock responded that the quality and cost metrics are not similar between the two examples, assenting that there are value differences in the spectrum of COEs.

Members reviewed Reference Based Pricing ("RBP"). RBP refers to capping health care payments to providers at a fixed amount or "reference" price (commonly a fixed multiple of the Medicare reimbursement rate), in lieu of paying a discounted rate off the billed provider charge. RBP on its own does not link quality to value, and therefore falls outside the APM Framework.

RBP increases the potential for provider disruption, and the risk of balanced billing. Implementation of RBP would require a significant upfront investment in time and financial resources. Historically, RBP is limited to a small number of services with higher cost and local competition.

Recently three other states have considered RBP: Montana, Oregon, and North Carolina.

Montana implemented RBP in 2016 and has realized savings of $13.0M in three years, with a reference set at 234% of Medicare across all service types.

Oregon passed legislation in 2017 that will take effect January 1, 2020, with a reference set at 200%.

The North Carolina Board of Trustees passed RBP in 2019. After being met with significant opposition from NC based providers, a modification was added. RBP is scheduled to be effective 2020. The reference is set at 196% of Medicare. The PPO network will be offered alongside the NC State Health Plan Network.

Mr. Oberle did not want Members to be deterred by the upfront investment of time and financial resources, adding that Members discuss ways to avoid balanced billing. He noted the presentation by Johns Hopkins researchers that illustrated hospitals can operate on Medicare reimbursement rates alone.

Mr. Costantino queried how the Oregon legislation addressed balanced billing. Mr. Fyock will research.

Ms. Anderson requested more information, including the methodology of setting reference ceilings, and options to negate the risk of balance billing. Mr. Fyock noted that the remainder of his presentation includes an overview of the RAND study that will provide more detail.

Mr. Costantino referred to studies that show RBP results in cost shifting. Mr. Fyock provided a balloon analogy; as you squeeze the balloon, the volume doesn't change – it just shifts.

The Affordable Care Act limits cost-sharing or essential health benefits to $7,900 for self-only, and $15,800 for other than self-only coverage. Employers should ensure adequate and timely access to high quality providers accepting RBP, and establish and communicate an exceptions process when access to a provider that accepts RBP is unavailable. Emergency services should be excluded. Plan information on providers and pricing should be transparent and provided upon request. The Plan should ensure that an adequate number of providers accepting RBP meet reasonable quality standards. Plan sponsors considering RBP should seek additional information regarding potential member liability, increased operations support and compliance. RBP could be part of a hybrid plan.

Treasurer Davis said it would be helpful to see the average percent paid above Medicare reimbursement across the State. Mr. Fyock responded that he will provide more information to establish a baseline. Mr. Oberle added that he would also like the rates charged by freestanding facilities, as well as SurgeryPlus.

Mr. Costantino stated that he would like to see the methodology used by Montana to set their reference. Mr. Fyock responded that there could be an opportunity to dialogue with the States themselves.

There was a consensus that more data is needed, and more research regarding the potential for cost shifting of expenses not covered by Medicare.

The RAND study is an employer led initiative to report hospital care pricing. There have been two rounds of the study and the third is currently scheduled for release in Q1 of 2020. Delaware is participating in Round three and will receive in a custom report.

Nationwide, the average employer payment to hospitals for the same services, from 2015 to 2017, went from 236% to 241% of Medicare pricing. Michigan was an outlier, experiencing a decrease in overall multiples of Medicare, from 168% to 156%. The variation in hospital pricing from state to state in 2017, was 150% to 300%, and the variation by hospital system was 150% to 400%.

Ms. Anderson queried if more data was available regarding Michigan's 8% decrease in overall multiple of Medicare pricing. Mr. Fyock responded that he will investigate to see if the drop was the result of action, or if it was organic.

Mr. Taschner expressed long-term frustration over the lack of available data. He inquired about how reliable the results of the study would be. Dir. Rentz responded that SBO is in conversations with Delaware Health Information Network ("DHIN") who oversees the new Health Care Claims Database ("HCCD"). RAND will be using data from the HCCD. The data available for the payers of the fully-insured block is still being cleaned and analyzed, and Dir. Rentz is not confident that the data will be ready for delivery to RAND by the deadline. She will keep members updated.

Mr. Costantino asked if the RAND study was all self-insured. Dir. Rentz responded that the study primarily looks at self-insured, but several states have All-Payer Claims Databases ("APCD") reporting all claims. Mr. Costantino added that the most robust APCDs are limited in self-insured claims and non-medical claims are also not captured. He was doubtful that ACPDs will get the breadth of the self-insured side. Dir. Rentz responded that RAND has only used APCD data in a handful of states. Dir. Rentz will verify, but stated that approximately 70% of the State's population is in database (state and self-insured), and she believed it was a fair representation of the State population.

Members discussed unintended effects of RBP on commercial rates.

OTHER BUSINESS
No new business presented.

PUBLIC COMMMENT
Wayne Smith represents the Delaware Healthcare Association and the hospital trade group. He stated that the discussion among members reflects a larger debate nationally. There is support for Value-Based Pricing ("VBP"), and he believed VBP is in conflict with RBP. He shared that North Carolina has not yet been implemented RBP, because only 5 out of 135 hospitals statewide have agreed to participate. He agrees that aligning incentives with value is positive. Hospitals are complex businesses, and therefore he disagrees with the Johns Hopkins researchers, stating that it is difficult or impossible for hospitals to survive on government only business. He noted local examples such as Nanticoke and Union Hospitals.

EXECUTIVE SESSION
A MOTION was made by Mr. Costantino and seconded by Ms. Thomas to move into Executive Session to discuss provider pricing in Delaware relative to Medicare pricing at 11:12 a.m.
MOTION ADOPTED UNANIMOUSLY

CALLED TO ORDER
Director Rentz called the public meeting back to order at 12:03 p.m.

ADJOURNMENT
A MOTION was made by Ms. Schock and seconded by Ms. Anderson to adjourn the meeting at 12:03 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