MINUTES FROM THE FINANCIAL SUBCOMMITTEE TO THE STATE EMPLOYEE BENEFITS COMMITTEE
December 5, 2019

A meeting of the Financial Subcommittee to the State Employee Benefits Committee (the "Committee") was held Thursday, December 5, 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, Dept. of Human Resources ("DHR") (Appointee of DHR Sec. Johnson), Chair
Ms. Judy Anderson, Delaware State Teachers Assoc. (Appointee of the DSEA, Jeff Taschner)
Mr. Steve Costantino, Dir. of Health Care Reform, Dept. of Health and Social Services ("DHSS") (Appointee of Sec. Walker) *(Telephonically)*
Ms. Judi Schock, Deputy Principal Assistant, Office of Management & Budget ("OMB") (Appointee OMB Dir. Jackson)
Ms. Ruth Ann Jones, Legislative Analyst, Office of the Controller General ("OCG") (Appointee for CG Morton)

Committee Members Not Represented or in Attendance:
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer
Mr. Keith Warren, Policy Director, Office of the Lt. Governor (Appointee of Lt. Governor Hall-Long)
Mr. Stuart Snyder, Chief of Staff, Dept. of Insurance ("DOI") (Appointee of Commissioner Navarro)

Others in Attendance:
Mr. Jeff Taschner, Executive Director, DSEA
Deputy Director Leighann Hinkle, SBO, DHR
Mr. Chris Giovannello, Willis Towers Watson ("WTW")
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Ms. Cherie Biron-Dodge, Controller, DHR
Ms. Julie Caynor, Aetna
Ms. Lisa Goodman, Hamilton Goodman Partners
Mr. Walter Mateja, IBM Watson Health
Ms. Jennifer Mossman, Highmark Delaware
Ms. Paula Roy, Roy Associates
Ms. Martha Sturtevant, Executive Assistant, SBO, DHR

CALL TO ORDER
Deputy Dir. Hinkle called the meeting to order at 10:01 a.m.

APPROVAL OF MINUTES – DIRECTOR RENTZ
The minutes were tabled due to lack of quorum.

DIRECTOR'S REPORT – DEPUTY DIRECTOR LEIGHANN HINKLE
Committee & Subcommittee Updates
The Health Policy and Planning Subcommittee will meet December 5, 2019 to continue discussions on primary care access. The Committee will meet December 16, 2019 to review executive summaries of the FY19 incurred reporting and High Cost Claimant data. They will also review an outline on the SBO Strategic Framework and consider the Proposal Review Committee's recommendation for supplemental benefits. An Executive Session is planned to continue discussions on health care contracting.

FINANCIALS –WTW
October Fund Report – Mr. Chris Giovannello
Additional revenue posted from a late premium collection from September reflecting higher than projected premium contributions. Claims remain over budget attributable to trend assumptions and primarily driven by

pharmacy. Medical claims were under budget. The fund is $3.4M above budget in claims through October. October has a negative net income of $6.8M, bringing the fund equity balance to $152.7M with a YTD variance of $3.75M.

Mr. Taschner inquired whether data was available to determine whether the increase in pharmacy claims was a result of cost or utilization. Mr. Giovannello responded that the data would be available in the near-term.

Plan Migration Analysis – Ms. Rebecca Warnken

The Subcommittee reviewed key findings of the Plan Migration Analysis.

There was a 22.3% engagement with the myBenefitsMentor tool. The tool provides an individualized cost estimate that pairs payroll deductions with out-of-pocket costs based on a member's claim data. 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, however 55.7% of members who used the tool still enrolled in highest cost plan.

Approximately 10% of Highmark's First State Basic ("FSB") members migrated to the Highmark PPO ("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 Highmark 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.

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.

43.9% of PPO families had allowed costs under $5K, indicating a willingness to pay higher premiums for a more comprehensive plan over lower premiums with potentially higher out-of-pocket costs. Alternatively, approximately 20% of FSB and Aetna CDH ("CDH") members had allowed costs over $10K, indicating a willingness to pay less in payroll contributions for potentially higher out-of-pocket expenses.

Director Rentz Arrived

CDH was the lowest cost plan recommended for 49% of the plan population 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.

Total contracts from the active employee and early retiree population in the four available plans in June 2019 was 44,862, compared to 45,067 in July 2019.

Demographically, single members were more likely to enroll in FSB, and families in HMO or PPO Plans. The CDH Plan attracts members with lower costs.

Consistent with trends in prior years the PPO continues to attract members with the highest average risk scores and had the highest admits and office visits per 1000. CDH and FSB members have the lowest risk scores overall.

FSB had the highest utilization of emergency room ("ER") visits, representing that some members prefer a plan with the lowest payroll deduction over plans that offer cost sharing features that encourage different sites-of-care.

Mr. Costantino queried whether the ER utilization data was expected. Ms. Warnken responded that the risk scores are higher in the PPO, but there are many contributing factors to why someone would utilize the ER.

Members requested a breakout of data regarding ER visits (emergent vs non-emergent) and office visits (well vs sick) data. Mr. Mateja will make further cuts to data by plan.

CDH has the highest well visits per 1000 and may suggest a higher engagement in healthcare. FSB has the lowest well visits per 1000, and the lowest compliance in preventative services that may indicate a younger, healthier demographic that does not feel the need for regular checkups and screenings.

Mr. Taschner queried how to communicate to members who migrated from FSB to PPO that the increase in the allowed amount Per Member Per Month ("PMPM") is not as great as their total out-of-pocket costs, adding that a supplemental policy paired with the plan may be a solution. Ms. Warnken responded that the State offers a critical care policy as a supplemental benefit, a current RFP has requested bidding vendors to propose solutions to address this concern. She added that there is opportunity to promote the utilization of the myBenefitsMentor tool and will recirculate FY18 data on myBenefitsMentor.

Mr. Taschner requested breakout of the 2020 enrollment data to compare plan enrollment by those who did and did not utilize the myBenefitsMentor tool.

Incurred Reporting – Mr. Chris Giovannello & Ms. Iglesias
Members compared incurred medical costs for FY18 to FY19 to identify cost drivers and evaluate whether the right initiatives are in place to control costs.

The top clinical conditions driving medical trend included chemotherapy (up 29.4% with a $3.9M increase in net medical paid), newborns with and without complications (up 14.9% with a $1.6M increase), coronary artery disease (up 13.4% with a $1.6M increase), respiratory disorders (up 11.0% with a $1.3M increase) and pregnancy without delivery (up 7.9% with a $1.4M increase). Ms. Warnken added that a review of High Cost Claimant ("HCC") data will provide further detail.

Diabetes was the most expensive episode of care for the GHIP population in FY19 with $45.2M net paid for medical and prescription claims with a trend of 18.4%.

Specialty drugs continues to be a significant driver. There was a 24.2% increase in the usage of the top 50 specialty drugs, contributing to a $12.0M increase in net paid. Immunosuppressants, antineoplastic agents and hormones & synthetic substitutes were the costliest therapeutic classes of specialty drugs.

There was an overall increase in utilization of behavioral health services. Mental health outpatient visits increased by 11.5%, and office visits increased by 5.9%. Substance abuse inpatient visits increased by 16.7%, outpatient visits increased 13.3% and office visits increased 10.3%. Behavioral health utilization data is captured separately from well visits and is broken out by visits to a mental health agency.

There was a $1.8M increase in maternity spend. Pregnancy and birth numbers were consistent, indicating the cost was related to complications.

There was an increase of 10.2% for outpatient radiology services, including a 35.3% increase in mammograms, a 20.1% increase in x-rays, a 18.7% increase in ultrasounds, and a 16.2% increase in nuclear medicine.

Members requested steerage data regarding outpatient radiology services. Data will be presented in a later deck.

While outpatient surgery utilization was flat, the trend increased by 10.2% for a total increase of $7.0M net paid. The procedures with the largest overall cost increases over FY18 were cardiac ablation ($2.1M total paid), upper GI endoscopy ($1.8M), cardiac catheterization ($1.3M) and shoulder arthroscopy ($1.1M).

There was a 1% increase in overall impatient surgery trend, with some significant plan-specific trends. FSB surgeries increased by 28.1%, HMO increased by 25.5%, and CDH increased by 12.6%. Procedures linked to HCC contributed to the increase in trend.

Opportunities to reduce medical trend and limit HCC include; promoting GHIP engagement and management programs for diabetes and maternity, further evaluation of cancer care resources and the competitiveness of the GHIP's drug pricing contract, and continued promotion of behavioral health resources, including those available through the EAP. Dir. Rentz added that SBO has begun collaborations with the mental health provider community to leverage programs and resources.

Mr. Taschner stated that the reverse online auction for pharmacy spend has been helpful to reduce pharmacy spend. Dir. Rentz is exploring progress made in other states regarding pharmacy pricing.

High Cost Claimant Reporting – Ms. Jaclyn Iglesias

HCC are defined as having incurred claims greater than $100K in a given reporting period. HCC spanned all ages, member types and status groups, but were most often aged 50-59 years old (35%) and spouses (61%).

The prevalence of HCC has increased from FY16 to FY19 from 6.1 to 7.4 HCCs per 1,000 members. The total cost attributable to HCCs increased from 22% to 25% of net payments. From FY17 to FY18 the cost per HCC increased 15.5% in net paid PMPM vs minimal increase for non-HCCs.

Data was isolated to determine which members have had a one-time event vs a critical illness over multiple years. In FY19 there were 766 HCCs, 283 were HCCs in multiple years, and 43 met this threshold in all of the past four years (FY16-FY19).

The top clinical conditions driving multi-year HCCs were conditions associated with newborns, cancer (breast, leukemia and lung) and coronary artery disease. The top clinical conditions driving FY19 HCCs were similar to those in the multi-year population.

One of the top ten most expensive HCCs in FY19 has been a HCC for all four years, has been continuously enrolled in the FSB as a non-Medicare pensioner, and is engaged with a Highmark nurse care manager.

Skin burns, congenital respiratory disorders, and mental health treatment related to schizophrenia have the highest costs per patient but are not driving overall costs as there are few of these claimants.

The costs and occurrence of HCCs can be mitigated with member education, preventive care, and effective management of chronic conditions.

In FY19, net payments ranged from $100,320 to $1,869,030. Of HCCs in FY19, 61% were not a HCC in prior year and 2.3% have been enrolled in Medicare.

There were only 4 additional cases of newborn HCCs, but net payments increased by $3.2M.

Mr. Costantino queried whether the State had considered stop-loss insurance. Dir. Rentz responded that the State has considered insurance in the past, but the rates were too high. Ms. Warnken added that insurance is priced so that the plan pays more in premiums than the insurance pays out. She added that if the plan can absorb the higher spend in high years, then recoup in low years, the only benefit is predictability.

Members discussed redefining the threshold amount for HCCs and whether it should be increased to align with higher costs. WTW will research.

Members reviewed a breakout in the data by member relationship and by status. Mr. Taschner requested further breakout to see relationship and status combined. He also requested total number of HCCs back to 2015. WTW will provide.

GHIP Impact Analysis – Mr. Chris Giovannello

The Subcommittee reviewed the results of initiatives, site-of-care steerage plan design changes, and clinical management program changes from FY16 to FY20.

From FY17 to FY19 the utilization of the ER for non-emergent and primary care treatable conditions 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.

From FY17 to FY 19 the utilization of hospital-based imaging facilities increased slightly, while freestanding imaging decreased slightly. Results indicate that the plan design change was only effective in steering care in the first year.

It is recommended to communicate copay differentials in years where there are no plan design changes to promote and sustain appropriate site-of-care utilization over time.

Members discussed behavioral economics and whether the dollar differential is not high enough to sustain long term change. Site-of-care may also be steered by doctor referrals. Results from the FY20 design changes will be helpful to the Health Policy & Planning Subcommittee in making future recommendations.

FY18 to FY19 saw a reduction in basic imaging services provided by hospital-based facilities, while freestanding facility utilization increased 8%. Plan design changes were effective at steering to freestanding facilities. The FY20 copay differential is expected to continue the trend, but ongoing communications are recommended.

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. Plan design changes were effective at steering to preferred labs. The FY20 copay differential is expected to continue the trend, but ongoing communications are recommended.

Other interventions to promote site-of-care steerage included the Aetna program for infusion therapy. In place before FY16, 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. Cancer drugs are not included.

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

The Subcommittee reviewed 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.

While the PPO Plan has the highest risk scores, the CDH and HMO Plans also had significant increases in FY19 attributable to HCC.

In addition to the top HCC conditions, members reviewed other top clinical cost drivers by plan not captured in the top five. 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 have improved across all plans from FY18 to FY19, however breast cancer screenings decreased over the same period and across all plans.

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

Mr. Costantino queried whether the goals for GHIP preventative care and screenings were aligned with national benchmarks. Mr. Mateja responded that the clinical protocol may be proprietary, but he will work to provide additional context.

The Subcommittee reviewed the chronic disease burden across the GHIP population. Unmanaged or poorly managed chronic disease can contribute to higher prevalence of HCC. 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 most expensive episode of care. There is good compliance across the diabetic population of the GHIP, however ongoing education is recommended.

There is opportunity to improve member communications regarding alternative sites-of-care, promote preventive care/screening compliance and management of chronic conditions across all plans, and to explore services and programs that support members in the top condition/cost categories. Additionally, there is an opportunity 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.

Mr. Costantino queried what data was available to validate the initial assumptions on savings and effectiveness of the programs would be determined. Ms. Warnken responded that cost avoidance is difficult to measure but comparing the costs of different sites-of-care with steerage results can provide an estimate. Ms. Iglesias will recirculate prior reporting on site-of-care steerage savings.

SBO STATEGIC FRAMEWORK – DIRECTOR RENTZ & DEPUTY DIRECTOR HINKLE

In addition to the updates to the GHIP Strategic Framework, the SBO is updating their Strategic Framework and will present an overview of goals and a timeline to the Committee. The new SBO training team will support the GHIP with targeted outreach, enhanced member engagement and education, and exploring benefit enrollment options. Additionally, SBO will review goals for additional work outside the focus of the GHIP including: Return to Work outreach, Disability Benefits administration and increased engagement with agency and school leadership and Human Resources.

OTHER BUSINESS

Dir. Rentz distributed the Site-of-Care Steerage report.

PUBLIC COMMENT

Ms. Paula Roy commented that changes to the local infrastructure have an impact on where members choose to receive care, adding that convenience of location affects behavior.

ADJOURNMENT

A MOTION was made by Ms. Anderson and seconded by Ms. Jones to adjourn the meeting 11:55 a.m.
MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

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