MINUTES FROM THE HEALTH POLICY & PLANNING SUBCOMMITTEE TO THE STATE EMPLOYEE BENEFITS COMMITTEE
FEBRUARY 7, 2019

A meeting of the Health Policy & Planning ("HP&P") Subcommittee to the State Employee Benefits Committee (the "Committee") was held February 7, 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
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)
Mr. Tanner Polce, Policy Director, Office of the Lt. Governor (Appointee of Lt. Governor Hall-Long)
State Treasurer Colleen Davis, Office of the State Treasurer ("OST"), Committee Member

Committee Members Not Represented or in Attendance:
Ms. Victoria Brennan, Sr. Legislative Analyst, Office of the Controller General ("OCG") (Appointee for CG Morton)
Mr. William Oberle, Delaware State Trooper's Association (Appointee of the DSEA, Jeff Taschner)
Ms. Molly Magarik, Deputy Secretary, Department of Health and Social Services ("DHSS") (Appointee of Sec. Walker)

Others in Attendance:
Deputy Director Leighann Hinkle, SBO, DHR
Mr. Kevin Fyock, Willis Towers Watson ("WTW")
Ms. Jaclyn Iglesias, WTW
Ms. Christina Bryan, Delaware Healthcare Association
Ms. Nina Figueroa, Policy Advisor, SBO, DHR
Ms. Katherine Impellizzeri, Aetna
Ms. Martha Sturtevant, Executive Assistant, SBO, DHR
Ms. Susan Steward, Policy Analyst, OST
Ms. Caryn Shetzler, Trainer, SBO, DHR
Mr. Walter Mateja, IBM Watson
Ms. Kimberly Jarrell, Member of the Public
Mr. Daniel Jarrell, Member of the Public
Ms. Lisa Mantegna, Highmark Delaware
Ms. Meghan Lynch, Support of SB 139
Ms. Deborah Hamilton, Hamilton Goodman Partners
Ms. Christine Gross, Stand Up for Fertility Delaware

CALLED TO ORDER
Dir. Rentz called the meeting to order at 1:07 p.m.

APPROVAL OF MINUTES – DIRECTOR RENTZ
A MOTION was made by Ms. Schock and seconded by Mr. Polce to approve the minutes from the January 24, 2019 Joint Subcommittee meeting on behalf of the Health Policy & Planning Subcommittee.
MOTION ADOPTED UNANIMOUSLY.

DIRECTOR'S REPORT – DIRECTOR RENTZ
The Johns Hopkins researchers are working to provide the risk adjusted analysis requested by the Committee and additional analysis requested by the Joint Subcommittees on January 24, 2019 as it pertains to regional referenced based pricing. SBO will continue to follow up with Johns Hopkins.

The Committee met on January 14, 2019 and reviewed the recommendations by both Subcommittees. It is expected that the Committee will vote on plan design changes on February 11, 2019. The Committee is likely to defer a vote on premium rate increases, pending Q2 financials and the review of the best and final offer received on the prescription contract renewal.

FERTILITY CARE/IVF SERVICES – MS. CHRISTINE GROSS, STAND UP FOR FERTILITY DELAWARE

The Committee is being asked to consider adopting SB139 since the law does not apply to the State of Delaware GHIP plans. At the request of the Committee, the HP&P Subcommittee has been asked to evaluate the adoption of SB 139. Dir. Rentz reminded attendees that the Subcommittees are advisory committees, and that the Committee is the voting body.

Ms. Gross stated for the record that she is not a paid lobbyist or a member of the GHIP. She shared her personal and financial experience regarding infertility, and the insurance challenges she faced when applying her limited benefits. As a result of her experience, she decided to advocate for other patients in her situation. Ms. Gross reported that one in eight self-report that they have experienced infertility, though actual numbers may be under reported. Cost is the primary reason patients do not move forward with treatment.

Ms. Gross stated that SB 139 was passed to provide comprehensive fertility coverage, increased transparency, and fertility preservation, noting that infertility can be an unintended consequence of necessary medical treatment (e.g. cancer).

Delaware is the first state to recommend the use of Single Embryo Transplant ("SET") in the law. The number of embryos transferred does not increase the success rate, but does increase the chance of multiples. The cost can be five times more for a twin pregnancy, and twenty times more for a triplet pregnancy.

Nationally 3% of those diagnosed with infertility require In Vitro Fertilization ("IVF"). Delaware practices reported that 15% of patient volume move on to IVF. Not all patients will require IVF, but some diagnosis require it. Ms. Gross stated that each member should have personalized treatment based on their diagnosis that best optimizes their outcomes, rather than being required to use their lifetime maximum on treatment not recommended for their condition. For those who meet the diagnosis allowing IVF, SB 139 allows for 6 completed egg retrievals per lifetime with unlimited embryo transfers.

Ms. Gross addressed the concerns regarding age limits. Doctors do not treat patients based on age alone. She stated that genetic testing lowers the miscarriage rate to 5%, even in older mothers and that genetically normal embryos transferred up to age 50 have up to a 70% success rate. She added that a woman can still carry a pregnancy at that age. Recommended transfers up to age 50 takes into account a woman who has purchased donor eggs, and may have remaining embryos she does not want to abandon because of cost.

Treasurer Davis stated that she would like to see statistics included regarding the risks to the mother (e.g. cancer as a result of hormone exposure, and increased cardiac stress at an advanced maternal age). Ms. Gross responded that she discussed with her doctor that low doses were not correlated with cancer. She added that pregnancy at any age increases cardiac stress, and that patients being treated for infertility should not be treated differently than other pregnancy patients.

CURRENT GHIP INFERTILTIY BENEFITS – DIRECTOR RENTZ

Currently members have a $25K lifetime cap, including up to $10K in medical benefits and $15K in pharmacy benefits. Additionally all services are subject to a 25% coinsurance. Ms. Gross added that the coinsurance for fertility treatment is the highest across all GHIP benefits. Dir. Rentz responded that the subcommittee could put forth a recommendation to amend the coinsurance.

Highmark and Aetna currently cover retrievals before age 45. Highmark covers transfers before age 45, and Aetna covers transfers before age 50.

In terms of eligibility and exceptions, Highmark does require first utilizing lower cost treatments before covering IVF, but Highmark states that each case is reviewed on an individual basis. Aetna requires no more than 3 cycles of Ovulation Induction or Intrauterine Inseminations before covering IVF.

Dir. Rentz summarized the Committees concerns: unlimited embryo transfers, age limits, funding, and best practices. She stated SBO would be follow up with Aetna, Highmark and providers to determine the average costs of services and to present this information at the next discussion. She asked the Subcommittee to reach out to her with their ideas on what information would be beneficial in recommending a best practice plan design.

HEALTH SAVINGS ACCOUNT PLANNING – MR. KEVIN FYOCK, WTW

The Committee is considering the option of implementing a Health Savings Account ("HSA") plan as early as July 1, 2020. A HSA plan is a tax advantaged medical savings account.

A RFP Committee determined that both Aetna and Highmark meet the requirements to administer a high deductible health plan with a HSA plan, but there are additional key decisions associated with an HSA to be made by the Subcommittee before going back to the Committee with a full proposal in the June timeframe.

The Medical Third Party Administrator ("TPA") provides the same health plan processes; including enrollment, provider network management, claim adjudication, health management programs, and provider cost tools. However, a HSA plan is different because the IRS mandates a certain deductible and out of pocket limit in order to take advantage of the tax advantages. The member has a higher deductible responsibility before benefits apply[1]. Another notable difference is that the prescription drug costs must be paid at 100% by the member until the deductible is met and before non-preventive services are paid.

Mr. Snyder asked if there had been any analysis of how employees fall into tax brackets to determine what state employees might take advantage of a HSA plan. Mr. Fyock stated they had compared other state plans, but had not done an analysis to determine potential tax advantages. Ms. Iglesias stated that the presentation includes statistics on members by age and salary threshold.

There is a minimal annual deductible of $1,350 per individual and $2,700 per family[1]. There is a maximum annual HSA contribution of $3,500 per individual and $7,000 per family. Members 55 and older may contribute up to an additional $1,000 per year prior to enrolling in Medicare.

A HSA enrollee cannot have first dollar coverage thru another plan (e.g. Flexible Spending Account ("FSA") or access to a spouse's plan). There is an active RFP to select a FSA vendor with the intent to change the plan year of the FSA plan to align with the medical plan year. Therefore, the change in the FSA plan would eliminate a barrier for members looking to coordinate plan enrollment.

Mr. Snyder had concerns that unpredictable prescription expenses makes having a HSA plan precarious for the average member. Mr. Fyock stated that prescription coverage is the part of an HSA plan that members are most vocal about, and that educating members to adequately plan for the care is a priority. Mr. Snyder asked if they get a negotiated rate or pay full-price for prescriptions. Ms. Iglesias responded that HSA members would pay a negotiated rate that would be lower than not having insurance. Treasurer Davis expressed concerns that information regarding the pricing of prescriptions is not available to members until enrollment in the plan. Mr. Snyder expressed that a HSA plan is unnecessarily complicated and too high a risk for members.

The State will not save money by offering this plan, as it will be revenue neutral. The intent of offering an HSA plan is to increase member choice, and to help with recruitment and retention. The members most likely to participate will be millennials and members nearing retirement wishing to save for health care expenses in retirement through a tax advantaged account. Treasurer Davis cautioned that debt later in life is often a result of unanticipated medical expenses.

The State has discretion over the timing and frequency of funding the account.

[1] Deductible does not apply to well-visits or preventative medicine or accumulate toward the out of pocket maximum.

The State could fund its entire portion in one lump sum, providing immediate protection at the beginning of the plan year. This is administratively the most efficient option for funding. Unlike the Health Reimbursement Account ("HRA") associated with the CDH Gold plan, this is a realized expense to the State on day one and there would be no payback requirement. It is estimated that the State would forfeit approximately $100K per year as a result of employees terminating throughout the year. Ms. Steward noted that the average State resignation is 5 years 8mo, and 23% of those remain in State government.

Alternatively, funding member accounts could be made on a fixed per-pay, monthly or quarterly basis, where members would accrue funding throughout the year. These options could result in members paying more out of pocket up front, and it is more administratively complex for the State.

Members can contribute annually up to $7,000. If the State starts the fund with a deposit of $2,000, the member can contribute up to an additional $5,000. The more the State deposits, the less the member can contribute to a tax advantaged account.

Treasurer Davis expressed that the most responsible option is to fund member accounts upfront. Ms. Steward added that not doing so could put strain on members. Mr. Fyock added that upfront funding is the most common option in the first year of rollout, but could be amended in later years.

There are currently 2,600 employees enrolled in the CDH Gold Plan, of which 88% have an outstanding balance in their health HRA. As a result, if the State were to eliminate the CDH Plan, members would lose access to that balance.

There are several considerations for the HRA funds. The State could choose to set up a Premium Holiday HRA, allowing members to tap into those funds to pay for coverage in lieu of payroll deductions. Members could be provided with a Limited-Purpose HSA account that could be used to cover non-medical, yet health related expenses (e.g. vision, dental). Remaining balances could be set up as a Post-Deductible HRA, where members can use funds to pay for medical expenses after HSA plan deductible has been met. Alternatively, a Retirement HRA option that would allow members to take the funding into retirement.

Mr. Polce asked about the administrative aspect of setting up a retirement HRA. Ms. Iglesias stated that administratively is the most difficult option to implement, with the easiest being the Limited-Purpose or Post Deductible HRAs and are the most prevalent options when switching from a CDH plan with outstanding balances.

Ms. Shock queried whether the Limited Purpose HRA would offer members access to funding who are currently enrolled in a dental and vision plan, or if the funding could be used to enroll in new GHIP coverage. Ms. Iglesias responded that due to compliance considerations the State should consider limiting HRA fund availability to members currently enrolled in GHIP dental and vision plans.

Ms. Iglesias requested that the Subcommittee provide additional feedback to Dir. Rentz by 2/15 on HSA plan design scenarios, amount and timing of the HSA seed money, and thoughts on continuing the CDH Gold Plan, including options for CDH enrollees with a balance in the HRAs.

PRIMARY CARE LANDSCAPE & UTILIZATION – DIRECTOR RENTZ

Members are concerned with decreased access to Primary Care Providers ("PCP") as a result of perceived reduction in provider participation. SBO is actively participating in the Primary Care Collaborative meetings. The link to the recommendations included in the Primary Care Collaborative Report that was issued in January was emailed to the Subcommittee. Dir. Rentz presented a summary of the report, adding that recommendations and concerns will be addressed with Highmark and Aetna in upcoming contract negotiation discussions.

Dir. Rentz also reviewed summary information provided by Aetna and Highmark. Aetna indicates their PCP network has grown over the last three years. Highmark reported thirteen PCPs moving to a concierge model. SBO will

continue to gather information on the PCP networks including; open panels, number of Highmark in-network providers, and whether or not patients can get appointments with their PCP.

Data was presented by plan for PCP preventative care utilization. Dir. Rentz encouraged the Subcommittee to communicate any additional information that they would like to see included.

OTHER BUSINESS
Dir. Rentz noted no new business.

ADJOURNMENT
A MOTION was made by Mr. Polce and seconded by Mr. Snyder to adjourn the meeting at 3:01 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