**State Employee Benefits Committee**
**May 29, 2009, 1:00 p.m.**
**Tatnall Building, Room 112**
**Dover, Delaware**

The State Employee Benefits Committee met on May 29, 2009 at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

Ann Visalli, Director, OMB
Brenda Lakeman, OMB, Director, Statewide Benefits
Faith Rentz, OMB, Statewide Benefits
Ann Skeans, OMB, Statewide Benefits
Vicki Ford, OMB, Financial Operations
Mary Thuresson, OMB, Statewide Benefits
Casey Oravez, OMB, Financial Operations
Andrew Kerber, Department of Justice
Jill Ipnar, OMB, PHRST
Kim Vincent, Office of Pensions
Nick Adams, Deputy State Treasurer
Gary Pfeiffer, Secretary of Finance
Ronniere Robinson, DHSS
Lori Christiansen, Office of the Controller
Julian Woodall, Department of Insurance
Linda Nemes, Department of Insurance
Ed Tos, SEBAC Chair/DOL
Mike Nichols, SEBAC, DSP
Debbie Scanlan, DOE
Judy Anderson, DSEA
Tim Barchak, DSEA
Dave Leiter, DHSS, Facilities Op.
Kim Hawkins, City of Dover
Peggy Teal, City of Dover
Mary Pat Urbanik, U of D
Judy Grant, HMS
Dr. Paul Kaplan, BCBSD
Chris Alrich, BCBSD
Faith Joslyn, BCBSD
Jay Reed, BCBSD
Mike North, Aetna
Katherine Impellizzeri, Aetna
Wayne Kee, Dominion Dental
Brian P. Douty, FOP
Vincent B. McCann, AFSCME
Sandy Richards, AFSCME
Richard Phillips, DSEA retired
D. Bokob, AFLAC
Nancy Feldman, AFLAC
Clarice Kwasnieski, AFLAC

Agenda Items Discussed:

**Introductions/Sign In**

Ms. Visalli called the meeting to order at 1:03 p.m. Introductions followed.

**Approval of Minutes**

Ms. Visalli asked for a motion to approve the April 27, 2009 SEBC minutes. Ms. Christiansen made the motion to approve the minutes and Mr. Adams seconded the motion. The minutes were approved with unanimous voice vote.

**Director's Report**

Ms. Lakeman stated that Open Enrollment ended May 20, 2009. Approximately 550 attended the Benefit Fairs. There were 1,500 calls received during Open Enrollment, with 1,000 coming in the last three days. Of 35,000 eligible active employees in PHRST, 12,239 logged on to eBenefits to either view or change their benefits. Changes were minimal with the Blue Care HMO plan gaining 208 contracts, Blue Cross PPO plan losing 216 contracts, Aetna HMO losing 18 and the Blue Cross First State Basic plan gaining 25 contracts. Dominion Dental lost 137 and Delta Dental gained 471. Statistics are still needed from the University of Delaware, non-payroll groups

and the Pension Office. Plan changes from the members in those groups are expected to be in line with the changes reported for PHRST members.

**Fund and Equity Report – Vicki Ford (handout)**

An overview of the April Fund and Equity Report was presented. The net fund balance is reflective of the portion of the Medicare subsidy the SEBC approved to use to offset the FY10 anticipated deficit, as well as the $20 million surplus from the fund going toward the FY10 budget. The net fund equity balance is $6.1 million.

**Adoption of Revised Group Health Plan Eligibility and Enrollment Rules (handouts – 2)**

Ms. Lakeman stated that in September of last year there was an overhaul of the rules trying to capture federal and state changes occurring since 2003. Statewide Benefits is working to keep on top of these rules as changes occur. Most of the changes proposed today are simple housekeeping items, a couple of typographical errors and corrections to several areas where discrepancies between rules exists. An overview of the Proposed Substantive Changes for SEBC Consideration to be Effective July 1, 2009 was given. Each change was explained and questions answered. Sections that clarified or changed rules were fully explained, such as Section IV, Changes in Coverage, 4.12, as it needed language added in that "Pensioners and dependents eligible for Medicare, by reason of age or disability, must also enroll in Medicare Part A and B . . . ." Section V, Cost of Coverage, 5.14 d states "If an employee is terminated from employment and does not pay the employee share for the second half of the month in which terminated, coverage under the Plan is terminated as of the first of the month, any claims paid for that month will be reversed and a refund will be given, if the employee makes request for refund within 60 days." Ms. Lakeman stated these changes needed to be put in the Register of Regulations to be effective July 1, 2009. Ms. Visalli asked for a motion to adopt the Rules as presented. Secretary Pfeiffer made the motion and Ms. Christiansen seconded. Upon unanimous voice approval, the motion carried.

**Blue Cross High Tech Radiology Utilization Management Proposal – Dr. Paul Kaplan (handout)**

Ms. Lakeman explained that following the April 27, 2009 SEBC meeting she received a letter from Blue Cross Blue Shield of Delaware (BCBSD) explaining their intention to implement a utilization management program for high tech radiology services that would be effective the end of May. The Statewide Benefits Office informed BCBSD that the Group Health Insurance Program would not participate at this time and asked them to provide a presentation to the SEBC. A motion to vote would not be asked for today in order to allow time for further questions and answers. It will be brought up again at the June meeting of the SEBC.

Vendor Overview

- BCBSD has contracted with MedSolutions, Inc. (MSI), to provide radiology utilization management services to BCBSD members.
- MSI is an independent company that specializes in managing the utilization of diagnostic services.
  - Utilizes board-certified physicians, many with Delaware medical licenses
  - Accredited by NCQA and URAC
  - Established presence in Delaware; familiar with provider community
- Reviewed initiative with the Medical Society of Delaware.

Program Overview

- High-tech radiology services that will require a prior authorization from MSI include:
  - CT/CTA
  - MRI/MRA
  - PET
  - Nuclear cardiac imaging
- Services performed in conjunction with an inpatient stay or emergency room visit are not subject to prior authorization requirements.
- Appeal Rights:
  - MSI
  - BCBSD
  - External
- No financial incentive to MSI to deny care
- Review adheres to national guidelines
- Provider liability if a denied service is performed

Why is BCBS Instituting this Change?

- Adherence to a national standard of care for imaging services
  - Criteria reviewed and approved by BCBSD provider community
- Improve patient safety
- Control costs

Patient Safety

- Reduce radiation exposure
  - Future increased risk of malignancy
- Avoid need for additional studies due to non-issues seen on initial scan
- Reduce scans being done with inappropriate equipment

Authorization Requirements

- Referring (ordering) physicians responsible for obtaining the authorization from MSI.
- Imaging facilities responsible for confirming authorization before providing services.
- Authorizations can be requested by both in- and out-of-network providers.
- Retro-authorizations will only be provided and accepted if:
  - The service is clinically urgent and meets established criteria; and,
  - The request for the retro-authorization is received within 60 days of date of service.

Authorization Process and Criteria

- Providers can request authorizations online, by fax or by telephone
- Criteria for authorization of a test available for doctors to view online

Provider Liability

- Services performed by a network radiologist without the required authorization from MSI may be denied payment.
  - If payment for a service is denied, a provider may **not** seek reimbursement from the BCBSD member. Payment becomes a provider liability.
  - Should a member request that a radiology service be performed, even though MSI denied the request, payment becomes a BCBSD member liability.

State of Delaware's Historical Spend

- January 1, 2008–December 31, 2008:
  - $11,436,983
  - $11.59 per member per month (pmpm)
- 12,164 unique State employees/dependents received a high-tech radiology service
- Projected savings is for a program year from May 1 to April 30
  - Year 2009 Net Savings $950,427
  - Year 2010 Net Savings $1.45M
  - Year 2011 Net Savings $1.85M

Program Fees

- Authorization requests will be reviewed by MSI on a fee-per-case basis
  - The per-review charge is $35 (equates to $0.25 pmpm)
  - Included as a claims cost on account's invoice
  - Per-review charge will increase annually by three percent on the renewal date of the contract between BCBSD and MSI
- If a member is cancelled retroactively:
  Per-review charge of $35 will remain

Savings Guarantee for State of Delaware

| **Unmanaged trended baseline spend reduced by less than** | **Percent MSI fees at risk** |
|---|---|
| 10% | 100% refund |
| 20% | 10% refund |

Program Notes

- An authorization by MSI addresses medical necessity only; it does not guarantee payment.
- Ultimately, the member's benefits plan determines if a service is covered and at what level a high-tech radiology claim may be paid.
- To maximize member benefits, members should see a radiology provider who is in the BCBSD network.
- BCBSD members **not** covered under the MSI program include:
  - Medicfill / Medigap
  - BCBSD members who receive care outside of the BCBSD network area

Key Points

- Patient safety - reduced radiation exposure
- President Obama has mentioned making radiology utilization management a key cost savings feature in the future
- State of Delaware employees will receive medically appropriate care in accordance with national guidelines — and the Group Health Program will save money

Questions and answers followed. Dr. Kaplan stated there is over utilization of radiological tests in Delaware: 25% more CAT scans; 15% more MRI's; 3-5% more Pet scans. There are three reasons: 1) Doctors are scared of malpractice suits. 2) Many doctors own their own equipment which gives them more incentive to take the tests. 3) Some doctors don't adhere to national guidelines. Concerning patient, provider and doctor liability guarantees, Dr. Kaplan stated that the same policy in place for all services under our plans would apply. Anytime a member is seen by

an in-network doctor, the doctor understands they cannot bill a member if BCBSD determines the doctor is liable per contract. If a test is denied three people are notified: the doctor who asked for the test; the patient via a letter stating why the service has been denied; and the rendering physician.

Clarification and discussion related to the 3% escalator followed. Ms. Visalli had an issue with the contractual nature of the program costing $300,000 - $400,000 and noted that the committee should want a return on the investment. Net savings is estimated from a decrease in utilization. Ms. Visalli commented on the Committee's efforts with regards to wellness and how the result of wellness initiatives can be a healthier population. If this investment is made, what are we getting for it other than decreased radiology risk? She predicted that most people would prefer to have the risk in exchange for the service they would be denied. An investment in wellness or other initiatives which the Committee does not currently have the funding to do, may provide the longer term personal resolve in addition to quantifiable cost savings.

Ms. Visalli said that BCBSD does a pretty good job of utilization review already and we don't have a whole lot of unnecessary MRI's going on. She asked for an example of unnecessary use, for which Dr. Kaplan gave two. Further questions are to be addressed to Ms. Visalli or Ms. Lakeman.

**SEBAC Comment**

Mr. Tos commented that the SEBAC supports Ms. Lakeman's decision to opt out of the May implementation of the BCBSD utilization management of high-tech imaging as it may or may not be a good tool to help the State of Delaware manage health care costs. Before deciding whether to implement this proposal SEBAC requests that SEBC carefully review the program to determine that it's an appropriate area for utilization management and that the review process is professional and appropriate. Most importantly, that appropriate health care procedures are not denied. Any savings would result from denial of procedures ordered by physicians. The application of utilization management thru the BCBSD PPO Plan would be viewed by many subscribers as a fundamental change in the plan design and any implementation decision should provide state employees the opportunity to change their enrollment choices.

**Public Comments**

Tim Barchak – DSEA – concerning Eligibility and Enrollment Rules changes to Section 5.14 d. They recognize this is to capture money for the plan, but have a problem tracking the logic and fairness. Ms. Lakeman explained in detail how it works, along with describing how lag payroll works. Specifically, health benefits are paid for by the month and not just half of a month. If the entire month is not paid, a refund can be given if requested, but the benefits are terminated for the entire month and any bills for the month will not be paid. Examples were given. Ms. Visalli stated the rule is good, but suggested that employees need to be better informed about how this works prior to separation. Ms. Lakeman stated benefit representatives are educated in these procedures. Ms. Visalli offered help to the schools if they are having trouble with this. Mr. Leiter suggested that the state automatically subtract for an entire month upon termination. If an employee did not want coverage for the entire month, a request for reimbursement could be submitted.

Dave Leiter – DHSS – State Employee – He is totally for prevailing wages, but retirement benefits guaranteed when a person was hired should not change in any way under any circumstances. State workers have taken jobs at less than private sector wages, mostly for the benefit package and security. This is evident in the different pay rates that the State has for its own employees and what the state laws have as prevailing wages for contractors that come in and do our jobs and cut our overtime. Retirement health benefits are usually taken with a fixed income so raising the rates or changing the benefit package will do nothing but harm the retiree and those that depend on these benefits. We all plan on retiring at some point and I believe that we would like to think that those who make the decisions about our benefits are fair, honorable and duty bound to do what word was given and will not change in the middle of the game because private sector employers are lying to their employees.

**Other Business**

None.

Ms. Visalli reminded everyone that the next SEBC meeting was scheduled for June 22, 2009 at 1:00 p.m. She then stated that the Committee needed to go into Executive Session concerning appeals and asked for a motion to move to Executive Session. Secretary Pfeiffer made the motion and Ms. Christiansen seconded the motion. Upon unanimous voice vote the SEBC moved to Executive Session at 2:05 p.m.

Upon conclusion of Executive Session the SEBC moved back into the public meeting at 2:49 p.m. Being no further business, Ms. Visalli asked for a motion to adjourn. Secretary Pfeiffer made the motion, Ms. Christiansen seconded the motion. Upon unanimous voice approval the meeting ended at 2:50 p.m.

Respectfully submitted,

Mary K. Thuresson
Administrative Specialist
Statewide Benefits Office, OMB