Minutes of the
Retirement Benefits Study Committee

March 9, 2020 - 1:00 p.m.
JFC Hearing Room, Legislative Hall
Dover, DE

Committee Members Represented or in Attendance:

Rick Geisenberger	Chair, Secretary of the Department of Finance
Mike Jackson (represented by Bert Scogletti)	Vice Chair, Director of the Office of Management and Budget
Mike Morton	Controller General
Joanna Adams	Director of the State Office of Pensions
Faith Rentz	Director of the Office of Statewide Benefits and Insurance Coverage
Colleen Davis	State Treasurer
John Mitchell	Delaware House of Representatives
Ruth Briggs-King	Delaware House of Representatives
David Sokola	Delaware State Senate
Aaron Klein	Senior Vice President & Director of Performance and Analysis, WSFS
Jeff Taschner	Executive Director, Delaware State Education Association

Others in Attendance:

Jane Cole	Ned Landis
Bobbi DiVirgilio	Russ Larson
Dorothy Emsley	Rebecca Scarborough
Wayne Emsley	Stephanie Scola
Nina Figueroa	David Taylor
Kevin Fyock	Jim Testerman
Jamie Johnstone	Rebecca Warnkin

I. Call to order

Secretary Rick Geisenberger called the meeting to order at 9:00 a.m.

a. Introductions

Secretary Geisenberger asked the members and non-member attendees to introduce themselves.

b. Approval of the Minutes of the Meeting of January 7, 2020:

Minutes Approved

II. Summary of Prior Meetings

Rick Geisenberger, Secretary of Finance and Study Committee Co-chair presented slides 2 and 3, reviewing the summary of prior OPEB presentations.[1]

As part of this summary, Secretary Geisenberger reviewed the OPEB Liability, which is the Present Value of Future Retiree Healthcare Benefits, that was given for each of the following: Medicare, Pre-Medicare, and Enrolled Actives. The Inflation Assumptions (these are the same assumptions that the Pension Fund would use) and current Discount Rate used to calculate the Liability were also discussed. The Rating Agencies' concerns about Delaware's unfunded OPEB were quickly reviewed along with the Current Fiscal Impacts. Secretary Geisenberger also reviewed the list of different options listed on slide 4 that can be done to reduce the OPEB liability that have been presented in prior meetings. Slide 5 represent the options that we are continuing to explore.

III. Recap of Current State

Faith Rentz, Director of the Office of Statewide Benefits and Insurance Coverage, presented slides 6 and 7, providing the recap of the current retiree benefits. The focus being on the current Medicare retirees as opposed to the non-Medicare retirees. Coverage for a non-Medicare retiree and spouse is the same for an active employee. Therefore, this section is to focus on the retirees that are post age 65 and primary in Medicare coverage.

Currently we have about 25,500 retirees and spouses that are supported through the Office of Pensions, with their benefits being handled by the State Employee Benefits Committee. An employee can retire after 25 years of service at any age and can immediately begin collecting their pension and receive 100% State Share of health care costs. Employees who retire with 20 years of service can also retire and collect a pension and will received less than 100% of State Share based on their date of hire and their service schedule (outlined on slide 6). Secretary Geisenberger pointed out that unlike the pension plan, where whatever the benefit schedule is, it is being funded by a combination of employee contributions and employer contributions that are out of payroll, none of the retirement benefits are being funded aside from the .36% of payroll employer contribution, which is why we are on a path to far out strip the funds that are available.

Today Medicare retirees have a Medicfill supplement plan that has no deductible for copays as long as they are receiving services from an in-network provider. They also receive prescription coverage through Medicare Part B that is administered by Express Scripts. The copays assessed to the Medicare population is no more than the fees that are in place for active and non-Medicare employees and dependents. The current monthly

premium for Medicfill with prescription drug plan is just under $460 per month. For the majority of the Medicare retirees receiving the 100% State Share, they are paying zero dollars and for those who retired after January 1, 2012 they are responsible for 5% share of that monthly premium and are paying just under $23 per month per retiree and spouse. In addition, they are paying just under $145 monthly for their Medicare Part B which is deducted from their Social Security.

The maximum monthly State health care cost for a retiree and a spouse who are receiving 100% State Share is just under $920 per month.

IV. Future Considerations/Scenarios

Secretary Geisenberger introduced slides 8 thru 17 taking a look at the different scenarios that are really the tools on the benefit eligibility side, where they are going to outline what the benefit is and the monthly costs for retirees. Followed by a discussion on if they are going to do something like that scenario, what are some of the considerations and challenges to implementation and then a section on outstanding questions that you would expect people to have, where we don't necessarily have the answers right now and additional work will need to be completed to get those answers.

Director Rentz reviewed each of the different scenarios on each slide briefly stating that they would spend the majority of their time talking about the HRA and the Individual Market Place option. Referring to some of the options highlighted earlier by Secretary Geisenberger, they are trying to articulate through these slides giving everyone a better sense of how these scenarios would effect the retirees and their spouse, recognizing that these folks are on a fixed income.

<u>Reduction of State Share to 50% for Spouse</u>: Director Rentz read through the slides 8 and 9, providing the following highlights:

Coverage/Cost Impact:

- This would apply to future retirees, not affecting the spouses of current retirees.
- The reduction in the State Share would essentially impact the monthly premium. Currently ranging from zero up to 5%, this would increase to $230/month on the retirees' pension check each month, reducing the total State costs to a range of around $690/month for the retiree and spouse as opposed to $920/month.

Considerations/Challenges:

- This could create some implementation problems for the Office of Pensions, just having to identify and separate those in the different populations.
- Need to keep in mind that a delayed effective date could increase retirements among current State employees to avoid the impact to spousal coverage.

Questions/Outstanding Considerations:

- More consideration would need to be given to applying that reduction to all retirees.

- We do have child dependents in our Medicare population and need to make sure we consider how we would handle the reduction in the State Share for these dependents.
- Long term disability participants are managed through the Pensions Office, currently they are receiving 100% of State Share as long as they are a long-term disability participant. We would need to address whether or not such a change would apply to that population. Understanding this could create some financial challenges for them.
- Handing post-retirement family additions, clarifying that this could be dependents as well as new spouses (not a spouse when the person retired), etc.
- Double State Share is a benefit that was eliminated in 2012 and this applies to two individuals that were either employees or retirees married to one another prior to a certain date. These folks originally would not be charged any retiree contributions for their healthcare. This was changed to $25/month and then most recently it was increased to 50% of what the active or non-active care contract holder pays for that coverage.

Secretary Geisenberger added that you could obviously look at scenarios that are different percentages for the State Share for the Spouses (40%, 50%, 60%, etc.). As discussed earlier a lot of the other AAA States allow you to buy in at 100% (you pay 100% of the premium). There are lots of variations on each of these sides to take into consideration.

<u>Modify Years of Service & Percentage of State Share</u>: Director Rentz read through slides 10 and 11 providing the following highlights:

Coverage/Cost Impact:

- This type of scenario would apply to both the retiree and the spouse.
- The actual cost to the employee and spouse would be the same as it is today.
- The monthly costs to the retirees would be the same as current except for employees hired since 2007, it would then be based on years of service as outlined on slide 10.
- The monthly spousal monthly premium costs would be the same as current except for those employees hired since 2007, it would then be based on the years of service as outlined on slide 10.
- Under this scenario, for employees hired after 2007, if an employee stayed with the State for the 30 years plus, there would be no impact to the State costs. But, would reduce from 100% to 50% State Share for those employees who retire with 20-25 years of service and to 75% for employees with 25-30 years of service.

A question was raised by a Committee Member about whether this is the scenario that we would expect to reduce the liability by $9.6 Billion over a 30-year span? Director Rentz responded that this was correct.

Considerations/Challenges:

- This would affect the modeling accounts for the future retirees. However, another area that would need to be considered is the impact that this would have on the Pensions Office. This could affect both current and future retirees.
- Could be implemented in six months or less and can modify the State Share and retirement date to give flexibility in how this may be laid out following a statutory change.

Questions/Outstanding Considerations:

- Potential impacts on recruiting and retaining employees.
- How the effective date would impact employees closer to retirement.
- No other questions were added to this scenario.

Establish Minimum Age & Years of Service to Receive Healthcare: Director Rentz read through slides 12 and 13 providing the following highlights:

Coverage/Cost Impact:

- Sets a minimum age for employees to receive healthcare at age 60 for State and school employees and judges. Public Safety would be age 55.
- Retiree monthly costs would be the same as current except for employees less than age 60 (age 55 for Public Safety). No healthcare coverage for available through the State.
- All of the Spouses costs would be affected by the age requirements.
- State costs would be the same as the current retirees; except those that are less than age 60 (age 55 for Public Safety) who retire. Savings to the State could be as much as about $920/month for each individual that is no longer eligible for coverage.

Considerations/Challenges:

- Can be modified to adjust minimum age and years of service.
- Can be implemented in a rather short time frame following a statutory change.
- Potentially a delayed effective date could increase retirements to avoid impact to retiree and spouse coverage and that would minimize savings.

Questions/Outstanding Considerations:

- Should it only limit to age and not years of service.
- Would this have impacts on recruiting and retaining employees.
- How would the effective date impact employees closer to retirement.
- Could having employees remaining in the workforce longer have potential negative impacts on benefits and costs. This would be specific to disability benefits, perhaps a higher likelihood of workers' comp claims.

Secretary Geisenberger added that looking at other States this has been done and this is the one that is most targeted toward the pre-Medicare debt that we incur from the people who can retire at age 48 and both them and their spouse often going to another employer where they could get healthcare coverage. This option would get rid of that piece of it.

Eliminate Term Deferred Vested Benefits: Director Rentz read through slides 14 and 15 providing the following highlights:

Coverage/Cost Impact:

- Essentially if you leave State employment you are vested to receive your pension benefits at a later age but if you do not retire from the State and immediately collect a benefit, you will not receive healthcare benefits from the State.
- Similarly, this would impact the spouse the same.
- In terms of State costs, there would be no immediate savings, but there could be a savings of up to about $920/month if the State were not responsible for coverage for the individual and the spouse.

Considerations/Challenges:

- Could be implemented in a short time frame following a statutory change.
- Employees could leave State employment and come back as State employee in an eligible position, retire and would be eligible for benefits.
- This scenario would only effect employees who leave State employment and do not come back. They could get their pension but not the healthcare.

Questions/Outstanding Considerations:

- Would also have to consider the impact this would have on the recruitment and retention of employees and will there be impacts be different for the different ages.
- How would the effective date impact employees closer to retirement.

Health Reimbursement Arrangement (HRA)/Individual Marketplace: Director Rentz handed this part of the presentation over to Rebecca Warnkin and Kevin Fyock of Willis Towers Watson. Secretary Geisenberger added that the reason they are going to spend a lot of time on this is because this will have the largest impact on being able to find where the funding scenarios are more feasible. We think this can be done in a way that employees are no less and in many cases in a better situation.

Ms. Warnkin read through slide 16 providing a very high-level overview at this time and will be explained in more detail in the next section of this presentation.

Coverage/Cost Impact:

- This is really changing the way benefits will be delivered to retirees in Delaware, the current Medicfill would be eliminated and retirees and their spouses would be given an annual health reimbursement arrangement in the amount of $5,100 to purchase coverage through individual marketplace options.
- This amount is comparable in value through the State Share being provided today of $5,512.
- The difference being the underlying expenses for the current Medicfill which can be offset by rebates received is closer to $4,800 right now for calendar year 2020.

The HRA of $5,100 actually exceeds the underlying value of the coverage for that particular plan.

- The HRA is used to purchase a number of individual options.
- The Individual Marketplace has been in place in Delaware and nationally. The plans are already in the market and this would be providing a more direct way for retirees in Delaware to access that coverage.
- The HRA could be used to cover the premiums of those plans as well qualified out of pocket expenses and rolled over to future years.
- The coverage and cost impact will be reviewed in more detail later in this presentation.
- From a cost perspective the average monthly premium for would be about $225/month, roughly half of the premium for the Medicfill today. More details to come on this.
- In terms of State costs, the first year they are setting the HRA value roughly at the same value as the Medicfill plan. This does not necessarily reduce costs to the State immediately, but the longer-term liability reduction result of capping that HRA amount. This give the State more flexibility to define what that benefit is moving to a defined benefit approach.

Director Rentz reviewed slide 17 providing the following highlights:

Considerations/Challenges:

- Can allow for increase in HRA funding based upon healthcare trend, pension cost of living increases or other benchmarks.
- Upon a statutory change, this would require at least an 18-24-month implementation runway.
- Gives the majority of the existing retirees and spouses the ability to purchase coverage comparable to current coverage available to the State with additional funds.
- This scenario shifts the risk and administration of Medicare healthcare coverage away from the State.

Questions/Outstanding Considerations:

- This scenario will probably have many more questions and further research with regard to this option.
- Premiums offered today to active employees and retirees for dental and vision coverage are based upon the eligible population that would elect that coverage. So, they would have to assess the impact of having some of that population purchasing coverage on the Individual Marketplace and what effect that would have on the premiums. These are 100% employee and retiree “pay all” benefits.
- Discussion this morning is strictly for the Medicare retirees. However, there are options available for the pre-65 age retiree population as well that could be considered. Secretary Geisenberger added that this question interplays with the other strategies. For example, if you went to a mandatory retirement age that would shrink that pool and the problem becomes less. Therefore, there is interaction between this scenario and some of the others discussed.

- We do have retirees from some of their other participating organization and municipal government that also participate in the State's plan. They would have to be part of this transition to an Individual Marketplace as well.
- How does this impact the eldest current retiree population, is a safety net necessary, how would that be structured. Ms. Warnkin and Mr. Fyock will be discussing in detail what this could look like in the variations of our retiree population later in this presentation.

A Committee Member (Jeff Taschner) had the following questions that might need to be taken into consideration:

- If we were to go in this direction and remove the Medicare retiree population from the group health insurance plan, what would the impact be on the fund for the SEBC? His understanding is that what is put into Medicfill, the revenue exceeds the cost/expenses and he would be interested in knowing how this impacts the fund that is used to pay for the healthcare currently. Not saying that it should prevent from going in this direction, but also think need to be aware that we may be solving one problem and creating one in a different area.
- If we are going to discuss this at some point, he would be interested in knowing that if we start the HRA at $5,100 and we are assuming a 2% increase, looking at the inflationary assumptions alluded to before which were 4 to 5.4 in medical and 6.85 in pharmaceutical, there must be crossover date somewhere in the future. He would like to know what that crossover date is. What he means by crossover date is when does that cost of coverage now exceed the value of the HRA with the 2% annual increase that we are giving the retirees/future retirees. There will be a point where that will happen and he thinks we need to know…is it 3 years…15 years, etc. Depending on that the impact that we are looking on the individual retiree is going to be much different.

These are two considerations he wanted to add that he will be looking for answers for in the future.

V. HRA Details

Rebecca Warnkin and Kevin Fyock will review the Individual Marketplace with the HRA scenario in detail as presented on slides 18 thru 36.

Ms. Warnkin started with reviewing slide 18, showing that there are four other States that they are aware of that have implemented this Individual Marketplace with an HRA approach.

- Ohio: Implemented an annual allowance similar to what we are talking about doing here in Delaware. Based on age and years of service at retirement.
- Rhode Island: They benchmark the HRA against one of the Individual Marketplace plans, AARP Plan F. Whatever that rate is, that is the rate that is provided to the retirees in the HRA and it varies by age.

- Louisiana: Another State that has adopted this strategy for a portion of their retiree population. Provide an annual HRA contribution for single coverage of $2,400 and a retiree plus a spouse coverage is $3,600.
- Nevada: Annual HRA contribution is $156 per year of service (which is capped at 20 years of service). Retirees hired after 2012 are not eligible for an HRA but may enroll in coverage through the Medicare Exchange. There is also a number of local governments and public entities that have also adopted this approach and it is much more prevalent in the private sector.
- 41% of large private sector employers nationally are providing those benefits through an Individual Medicare Marketplace.

Committee Member, Taschner, added one piece of additional information. He reached out to some colleagues in Ohio. He understands that there are five different public systems in Ohio. This approach, from his understanding, was taken in only two of those public systems (smaller rather than larger populations) and in particular for educational employees in Ohio are not covered by this. It is important that we understand that in the Ohio situation, it is not the entirety of their population, but actually just a small segment. He would be happy to provide this information with Ms. Warnkin and Mr. Fyock.

Secretary Geisenberger added that if you look at each of these States, it seems to be an aged based reimbursement versus what we have been talking about. Which is a slightly different approach to not looking at age based, but rather allowing people to build up an account that would grow through their life (not one that they get to keep), this will be discussed in more detail later. This slide is just to show that there are some States that are starting to move in this direction, and we do not need to do it the same way they do it.

Ms. Warnkin went on to recap the financial model that was represented in the January meeting and additional details to follow (slide 19). A reminder that the amount that was modeled was $5,100 per retiree and another $5,100 for a retiree's spouse would be linked to a percentage State Share that someone is eligible for today. For example, if someone is eligible for 100% State Share, they would receive the full $5,100 and then it would be ratioed depending on how much they are eligible for. Based on the modeling that was conducted virtually every retiree in Delaware would be financially better off in the Individual Marketplace compared to the current Medicfill plan. They have noted 99% in theoretically everyone that they looked at in their modeling would be the same or better off with an average savings of $3,300 per individual retiree. This option would provide a more meaningful choice to retirees instead of just the one Medicfill plan administered by Highmark. A variety of plan options and carriers through the Individual Marketplace and 95% of GHIP retirees would have access to a $0 premium Medicare Advantage Plan. This will be covered in more detail. A note that there are 40 million retirees enrolled in individual Medicare supplement and Medicare Advantage Plans nationally. The carriers that are administering the Individual Medicare Supplement Plan are national carriers. Therefore, this does not necessarily disrupt the market in Delaware by adding additional lives to the Individual Marketplace.

Mr. Fyock stated that slide 20 builds on this and that was alluded to earlier, the idea of the Individual Marketplace as it relates to Medicare enrollees is not new. It has been around for decades, so this is more of a fundamental switch in how the benefits would be accessed using a connector in exchange to sort of directing people to coverage. There are very large risk pools, about 40 million retirees who are currently enrolled in Individual Marketplace plans. It is projected about 10,000 baby boomers turn 65 every day and this number will continue to expand at a rapid growth. Another interesting point about the Individual Marketplace that has changed in the past 10 plus years is there is not an adverse selection issue. Nearly everyone can join the marketplace at 65 (whether at the end of the group plan or alongside your group plan) and regardless of clinical state, whether healthy, chronic, catastrophic, etc. They have spoke a bit about carriers competing on prices and that is the key value proposition associated with the Individual Marketplace. Therefore, there is a significant number of national insurers who are in this space that Delaware would have access to, and they provide best in market plans. A retiree can pick the plan in a carrier that aligns with their current need and they can work with the connector to see which of those plans except the providers or the providers except those plans and enroll in the correct one for them. Another piece of this, is that all of the CMS/Pharmaceutical Industry Subsidies are available these plans. The benefits associated with a group plan today through the State of Delaware would carry forward through the Individual Marketplace.

Mr. Fyock went on to show the mechanics of how the retirees will enroll in this coverage if this idea was adopted (slide 21). The idea is that the State will provide a subsidy ($5,100 towards and HRA on annual basis). There would be a very lengthy and robust participant education process where retirees would educate on what this switch will look like, the resources available to those retirees. The next step after implementation is concluded the retiree will work alongside the "Connector" by the exchange through a technology and live support to choose the best in-Market Medicare plan that best aligns with their needs. The HRA reimbursement would then be made. The Connector doesn't go away at that point, they will continue to be available as ongoing advocacy support for the retiree. They will help with issues on premiums, out-of-pocket expenses, and just general questions about the plan they chose and the way that care is accessed.

Mr. Fyock reviewed slide 22 showing how the Individual Medicare Marketplace works. The "Plan Sponsor" would be the State of Delaware and following the arrows to the left, it highlights the Medicare Eligible Participants and their roles with the help of the Connector, resolving any issues or questions that may come up. The Medicare Marketplace itself has their roles, as listed on this slide, for all medical, dental and vision. On the righthand side of this slide, you see the types plans that members can enroll. A point that Director Rentz brought up previously was that this is just not for medical, it also includes dental and vision as well. The additional value is that the HRA can be used to purchase dental and vision coverage as well, that is not currently subsidized today.

Mr. Fyock added that they thought it was important to show a side by side review of an HRA, Health Savings Accounts (HSAs) and Health Flexible Spending Accounts (FSAs),

because these abbreviated terms can be confused with one another. He read through these differences as listed on slide 23.

He went on to discuss the option of a having a safety net to sort of protect retirees from any potential negative financial impacts. Some of these are listed on slide 24, just to show some potentials that the State could consider. These offer a level of flexibility to try to develop a way to protect the retirees from a financial perspective.

Ms. Warnkin began reviewing slides 25 thru 30 that show retiree household impact analysis reviewed in prior committee meetings and some additional scenarios that were modeled. Below are highlights she provided on these slides:

<u>Average Age, Average Utilizer (slide 25)</u>

- Plan HiF is a leaner less generous plan design but with lower premiums. This would have the retiree having the most funding left over after using their HRA to then cover out of pocket expenses. The out of pocket expenses would generally be higher.
- Plan N falls in the middle with some level of copays and retiree cost sharing with moderate premiums. This would give less out of pocket expenses.
- Plan G is the most generous plan design option available to retirees comparable to the Medicfill plan with the associated highest premium. This would also give the retiree even less out of pocket expenses.
- All of these plans (above) are Medicare Supplement plus Part D (prescription drug coverage).
- MAPD – for 5% of retirees in Delaware is a zero-dollar option. This plan gives the greatest retiree savings in this scenario, with zero-dollar premiums and the retiree can use the full HRA funding for reimbursing out of pocket expenses. This also gives a saving of approximately $2,200 that they can rollover into the next year. Compared to the current scenario, it is about $2,700 less than their current financial situation with the Medicfill plan.

All four options are more financially advantageous to the current Medicfill, it is just a matter of someone's individual circumstances, whether they would be better off in a Medicare Supplement type plan or an MAPD.

Secretary Geisenberger added that the current State plan for active employees works a little bit like this in that we get an analysis each year of what our actual utilization and spending is and tries to direct you to best plan out of the four different options. This option (above) gives you a lot more choices and options available to you. Ms. Warnkin added that this is where the Connector comes in helpful, because they can help the retiree work their way these many plans.

Committee Member, Treasurer Colleen Davis, asked a question referring to slide 24 "safety net considerations" about whether they have already done the numbers on how this may impact the overall savings for retirees. Mr. Fyock responded by saying that they had not done that because they had not determined how they would vary it

(by age, etc.?), the appeals process is hard to put a value on what that might be. They do not think that this would a material financial impact but looking for opportunities to find ways to make extraordinary circumstances whole and not disadvantage some folks that are in certain circumstances.

Senator Sokola stated that the State offers many plan options, but that most people are not experts on healthcare. The reality is that most people don't know what type of healthcare to choose. He would like to hear more about the support services ("Connectors") that will be there for the retirees. Basically, he is not necessarily sure that he likes having that many choices available. He would like to know that whatever policy will provide appropriate support to help retirees make the right decisions.

Representative Briggs-King stated that in the private sector there are navigators that help people look at the different policies/options and establish a relationship based on their current use and health, so that they can make the decisions. This is something that needs to be considered with how the State looks at benefits now and make sure we have those navigators and get people used to using them. Maybe having a navigator that helps people when they are looking to retire to look at everything holistically (medical, dental, vision, Rx, long term options, etc.) rather than just looking at this benefit plan vs that plan. This is difficult for people especially as they age and need to rely on others to help.

Mr. Fyock replied to the above statements by providing that he agrees that having that many plan options is a lot of for anyone to navigate. He went on to provide more of an explanation on what the Connector with the exchange would do. This Connector comes with the idea of having strong advocacy and there is substantial support at the point of enrollment. This support often takes some time initially (an hour or more) to develop that initial profile (medications they are on, doctors they visit, health, etc.). This is done to start aligning their options down to about two to three different plans. The advocate is still available to help the person review, compare and choose the best options for them. He again agrees that there are a lot of plan options and that this doesn't work unless you do have very strong advocacy at the point of enrollment to help retirees.

Joanna Adams, Office of Pensions, added that their office partners with the Delaware Medicare Assistance Bureau ("DEMAB") of the Dept. of Insurance. DEMAB helps their office when they are troubleshooting Medicare issues. She stated that they do have a lot of resources in Delaware to get the assistance needed as well.

<u>Low, Average, and High Utilizers (slide 26)</u>

- This slide recognizes that not everyone is the average and looks at a variety of different types of health plan users as follows:
    1. Lower Utilizer: Generally healthy, has a couple doctors, a couple prescriptions each year and only goes to the doctor a few times a year.
    2. Average Utilizer: In between the lower utilizer and the higher utilizer

3. Higher Utilizer: This is someone who has a hospital stay or more acute healthcare needs.

- A lower utilizer is better off in a Medicare Advantage type of plan because they are paying nothing in premiums for that plan. The out of pocket expenses are relatively low (office visits, prescriptions). They then would have a significant amount at the end of the year to rollover to a future year, for when they may have more acute health needs.
- A higher utilizer is paying less in premiums than the Medicfill plan and with potential higher out of pocket expenses, still could end the year with money leftover and saving money compared to the current Medicfill plan.
- Most of the retirees in Delaware are going to fall in the low and average utilization "bucket".
- The message on this slide is to show that there are options that could benefit all of the different categories.

Committee Member, Mr. Taschner questioned whether there was a profile for what a low, average, or high utilizer is. Ms. Warnkin stated they could share exactly what fuels these different profiles.

<u>Age 85, High Utilizer, Wilmington (slide 27)</u>

- To take the modeling a little further, they chose someone who is age 85, a high utilizer and residing in the Wilmington area.
- For this individual their premiums for a Plan G would be a little bit higher since they are older.
- They would still have a zero-dollar Medicfill Advantage Plan option.
- This model shows what their out of pocket expenses would be a little higher (since they are a higher utilizer).
- This particular type of individual would-be best-off enrolling in the Plan G with the most generous coverage, which give them a savings of about $639 compared to current coverage plan.
- Although they may not have funds at the end of the year to rollover, they would still be in a better financial position than they would be with the Medicfill plan.

<u>Age 85, High Utilizer, Dover (slide 28)</u>

- Same scenario as previous slide except the person resides in the Dover area.
- On average the premiums are a little lower in the Individual Market Place in Dover.
- The Plan G is a little lower than the person in Wilmington, but still enough to cover their premium, will have money to cover their out of pocket expenses and could end the year with about $200 to rollover to the next year.

<u>Age 65, Low Utilizer, Wilmington (slide 29)</u>

- In this type of scenario, the premiums are generally going to be lower for younger individuals.
- For a Plan G and since this individual is generally healthy their out of pocket expenses would be lower, they would benefit most by enrolling in a zero dollar

Medicare Advantage Plan and would have a significant amount of funding leftover at the end the year to rollover.

- They would close to $5,000 better off than they would be if enrolled in the current Medicfill Plan, largely because of the funding that they would be rolling over to a future year.
- Out of pocket expenses would be covered by the HRA.

There was some discussion regarding the dental and vision coverage as follows: No dental and vision coverage is considered in these models; these models are only for the medical and drug benefits. But, under these models, the individual could use the money that is leftover to pay for those benefits. Under the current plan, individuals pay the full cost of any dental and vision plan.

A suggestion was made that it might be helpful to take examples of an individual (maybe a low, average, and high) and go through their life cycle (beginning at retirement to age 100). To map out the current versus this view, to show the dynamic of the rollover. Slide 36 partially addresses this type of modeling (and it was shared in a previous meeting as well). Some further discussion was had on this matter.

<u>Age 65, Low Utilizer, Dover (slide 30)</u>

- This individual would be best off in a Medicare Advantage Plan.

Slides 31 through 36 are the Appendices for the items that have just been presented.

VI. Review and Approve DEFAC presentation

Secretary Geisenberger provided that under the Executive Order, the Committee is required to do a presentation to DEFAC. He went on to read through a proposed draft presentation for the upcoming March 2020 DEFAC meeting (slides 39 through 50).

Secretary Geisenberger then asked the committee members whether they agreed with the presentation. All agreed no objections were made, but the following suggestions were made:

- It would be helpful to add (on slide 40) a dollar amount where the slide shows you the retiree health insurance cost "pay-go" percentage.
- There was some discussion about slide 42 and whether it is a "straight on comparison". Therefore, when presenting to DEFAC they will make sure to address this.

VII. Next Steps

Secretary Geisenberger presented slide 53 showing the requirements of Executive Order 34 -- presenting findings to DEFAC; submitting a written report by March 31st to the Governor, General Assembly and DEFAC; and then the committee dissolves on April 15th unless it is extended. He then went on to read through the Options that are listed on this slide that are mutually exclusive, nor inclusive of all options.

Secretary Geisenberger asked that each committee member provide their thoughts and recommendations on the next steps, which is summarized as follows:

- Committee members expressed general consensus on the following:
  - Doing nothing is not really an option
  - The State needs to address this issue on a timely basis or risk its historic Triple A bond ratings
  - The sooner we get started the better – since some of these options have a longer timeline for implementation
  - The Committee should make recommendations that seek to actually make progress and get something done
  - A Joint Resolution approved by the General Assembly endorsing the need to address the problem seems like a good first step
  - A great deal of education, outreach and solicitation of input will need to occur with retirees and legislators on these issues to ensure that everyone comes together as part of the solution
  - Making changes to benefits and eligibility is part of the solution and it needs to be matched with additional funding as part of the solution.

Representative Briggs-King added that it may be feasible to offer an HRA option for pensioners on a voluntary basis. Treasurer Davis suggested that a pilot might be feasible.

Secretary Geisenberger suggested the Committee develop a draft joint resolution for consideration by the both Houses of the General Assembly and each caucus. This could be worked on over the coming weeks. It was agreed that any such resolution should be considered by the Committee in a public session. Secretary Geisenberger then stated that he would work to get something set up the last week of March 2020, to have time to work on the language and have a draft ahead of time to vote and in a public session. This path forward was agreed on by the committee. [NOTE: Due to the COVID Emergency, this course of action was subsequently deferred.]

VIII. Public Comment

Russ Larson – Mr. Larson's comment was that the State should not try to cut benefits for retirees. He also said that we should not do away with early retirement and retain the 20 years retirement with full benefits. Need a good system of pension increases each year, to make budgeting easier each year. Medical benefits should be left alone because copays are hard enough on the retirees. A recommendation should be made to place 1% of payroll in the OPEB fund that will make interest income pay for most of the medical benefits at one point in the future, that will also solidify our credit rating. Our State is ahead of most others in looking at this and we need to keep moving in that direction. He ended with stating that hopes that this is not a benefit reduction committee.

Wayne Emsley – Made a statement as the Executive Director of the Delaware Retired School Personnel Association. A copy of this statement is attached.

IX. Adjournment

Prior to adjourning Secretary Geisenberger recognized all of the work of Stephanie Scola, Director of Bond Finance, who has been doing a tremendous amount of work on the slide presentations. Ms. Scola is retiring at the end of this month. He and the committee thanked Ms. Scola for all of her hard work.

A motion to adjourn was made and seconded and passed unanimously.
The meeting adjourned at 11:21 a.m.

Respectfully Submitted by Bobbi DiVirgilio

[1] Presentation slides are available the Department of Finance's website at: https://finance.delaware.gov/financial-reports/committee-reports/ under Retirement Benefit Study Committee.

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Public Comment to Retirement Benefits Study Committee – March 9, 2020

My name is Wayne Emsley. I'm speaking on behalf of 13,000 retired public school employees. I spoke to this committee on November 26. At that time I asked you to look at health care from our perspective – the perspective of a retiree. I'm asking you to do that again today. I want to comment on two items.

First, our members, particularly our Executive Board, have been monitoring your meetings and have carefully reviewed the 12 scenarios that you have investigated to date. By far the most effective of these scenarios in reducing the unfunded OPEB liability are what we call scenarios "D and "E". Both would replace the present Special Medicfill with HRA's or Health Reimbursement Authorizations. We have developed 15 questions regarding HRA's that I'll be presenting to the Chair after my comment.

Both of these HRA scenarios would require retirees to purchase supplemental plans on the open market.

For the second part of my public comment, I want to share my personal experience on this "open market." Let me set the scene. It's Tuesday morning two weeks ago. I go to the gym, then I sit down at my computer about 9:00. I leave for a meeting at noon. In that three hour period I receive two calls offering me insurance to cover my final expenses, three calls offering to reduce my student debt and a call reminding me that my car's warranty has expired. In the spirit of full disclosure, I should add that I've never had any student debt or a warranty on my car. In the past I've gotten calls telling me that I owe Federal taxes, my electric bill is unpaid and something about Amazon prime. I'll be arrested or have my power cut off if I don't pay right away. On the plus side, I also gotten a few calls from the "US Government in Washington DC" telling me I've been such a good citizen that they want to give me $8,000.

In short, my phone - every retiree's phone - has become a weapon that tries to sell us things we don't need, or confuse us into falling for one of the hundreds of scams that are floating out there. What does this have to do with you, and more specifically the HRA scenarios that you are considering?

That Tuesday morning I went on the web looking for information on Medigap Plan G. I encourage each of you on this committee to try this also. What I found was in order to get information, I needed to give my name, address, email, birthdate and phone number at nearly every site. The selection process is too invasive. According to the most recent data available there are 3,085 pensioners 85 or older. Many don't own or use a computer. According to the presentation at your January 7 meeting, retirees would need to select among over 50 – and in some cases over 70 – prescription and medical plans. The selection process is far too complicated.

Geography is also a factor. Unlike active employees who live in or near Delaware, retirees can and do live everywhere. 11% of our members live outside of the area. How many other retirees live elsewhere? Will Medigap Plan G coverage and comparable prescription drug coverage be available to these retirees and at what cost?

We suggest that the State do the shopping for us and select the most cost-effective vendor. While retirees could "op-out" and select their own plan or plans, I think the vast majority of present retirees would elect to "opt-in."

We recognize that the Health Reimbursement Authorization plans are attractive. As presented by your consultants they actually save money for most retirees. They also save the state money in the short-term and significantly reduce the long-term OPEB liability. But as they say, "the devil is in the details."

If you choose to recommend implementation of an HRA, our organization – DRSPA – stands ready to work with the appropriate officials to sort out those details, making a painless transition for public school retirees.