

**Data and Information Request from DSEA regarding the State of Delaware Health Fund
June 8, 2010**

Below is a list of questions and a data request that we will need completed in order to review the latest proposal from the State (the presentation titled "Pension and Health Benefit Changes May 26, 2010").

Please note that, while we have strived to make this a complete list, during the course of the analysis additional information or clarifications may be necessary for the completion of the review. At that time we will provide you with any further information requests.

- What is the objective of the tiered benefit proposal? Cost containment, creating a two tiered benefit system, or achieving a lower employer cost share.
- What are the scenarios that support the need to implement the tiered benefit changes for pension and health care?
- What analysis and modeling has been done to support the proposal? Please provide.
- What are funding/expense projections for the next 10 years? Please provide inclusive of assumptions.
- Please provide the rate determination calculation for PY 2011. This should include experience information used as basis including updated utilization, unit cost, enrollment information, and assumptions, etc.
- Please provide healthcare related contracts—including provider discounts and administrative fee schedule.
- Confirm the lack of stop loss and reinsurance.
- Please provide a schematic to explain double state share, savings/costs, etc. Based on recent conversations, receiving two schematics (one from when double state share was implemented and one utilizing current rates) would help show why it isn't cost effective.
- The slide on page 10 of the "Pension and Health Benefit Changes May 26, 2010" presentation illustrates that the current State share for FY2010 is \$420 million, with the share increasing by \$54.9 million for FY2011. However, the slide indicates that the health care costs for the State increase 8% to 10% annually. The increase from FY2010 to FY2011 for the State is approximately 11.6%. What comprises the difference, which can be \$12.9 million and \$21.3 million?
- Has the State considered returning the approximately \$40 million removed from the fund during the last "premium holiday" where the State suspended contributions but the employees continued to make contributions?
- What consideration has been given to the impact of antiselection based on the implementation of a tiered benefit, itself based on tenure? The question is focused on, but not limited to:

- Drop off of proportional enrollment (as compared with prior years) of new employees who, based on statistical information, would be considered in the “young, invincible class” of employee (i.e. pays premiums but under utilizes benefits, thereby supporting higher utilizers).
 - Drop off of available pool for overall hiring for available positions within State employment (based on anecdotal information as to the reasons why people enter into government employment).
 - Migration by existing employees to other benefit programs (through spouses, purchasing coalitions, etc.).
- If the objective of the implementation of the tenure-based tier benefits approach is to save costs and mitigate deficits, what other approaches have been reviewed/explored that to not create a “caste” system within employee ranks?
 - What other considerations have been made, and options reviewed, in order to reduce the OPEB liability (i.e. migration of retirees to a Medicare Advantage program)?
 - Federal law (IRC Section 105H) indicates that, for self-insured benefit programs, tenure (length of service) is not an acceptable or allowable criterion to discriminate against otherwise similarly situated employees. Has the proposal for the tiered health care plan been approved from a legal perspective by the State Attorney General or the State’s ERISA/IRS counsel?
 - Please provide the calculations used to project the estimated savings as illustrated in the “Pension and Health Benefit Changes May 26, 2010” presentation for the five and seven year milestones. Include the underwriting factors and assumptions (i.e. trends, migration, employment shifts, external factors, etc.).
 - Do the projected savings as shown in the presentation eliminate any projected deficit in the Health Fund for the same time period (five to seven years)? If not, is the Fund going to consider current adjustments for future savings, or make corrections prior to each FYho?
 - What plans are in place to renegotiate/market the contractual relationships associated with the operations of the Fund?
 - Is there an audit scheduled for calendar 2010 to be performed on the Fund’s operations, with a focus on the claims portion of the Fund, to determine if claims are being paid accurately?
 - What wellness initiatives have been implemented or revised, and with what level of guaranteed return on investment?
 - Has an analysis of the network discounts been scheduled for 2010 in order to determine if the Fund is receiving the maximum impact for the benefit dollars being spent?
 - What plans does the Fund have for accessing the \$5 billion available through the Patient Protection and Affordable Cost Act (PPACA) through DHHS? As this is a “first-come-first-served” type of program the Fund should already have a plan in progress.

- Experience report (summary and by plan) illustrating financial results of the fund for the last 3 calendar years and YTD 2011
- Rate development by plan (for both budget rates and employee contribution rates) and assumptions used for the calculation
- Financial projections (summary and by plan) and assumptions used for the projections
- Monthly experience data for the last 3 calendar years and YTD 2011 for each plan:
 - enrollment by coverage tier
 - claim experience by coverage tier for: medical, prescription drug, dental (if applicable), vision (if applicable), other (please describe)
 - administrative fees (claim processing, disease management, and other TPA fees)
 - large claim information: list of claims over \$25K, applicable stop loss limit or pooling level, whichever is lower, recovery from stop loss coverage (if any)
- Current census information. We prefer to have both employee and dependent information (i.e. spouse and number of child dependents to each employee) – no identifiable information (e.g.: name, social security number, employee identification number) is necessary or desired.
- Any changes in employee demographics (e.g. early retirement windows, significant turn-over, reduction in force, etc.) in the experience period or in the future
- Any expected change in employee share of the plan cost (in employee contributions, not cost sharing built in the plan design)
- Summary of administrative costs/fees paid to vendors/consultants related to services provided to the Fund over the past three years
- If retirees are also included in the analysis, information for retirees will need to be separated from active employee. Medicare eligible vs. non-Medicare eligible retirees also need to be separated from each other
- Coordination method with Medicare (if Medicare-eligible retirees are covered in the analyses)
- List of funds transferred from the Health Fund or utilized for purposes other than the payment of claims and expenses incurred under the Health & Welfare benefit programs of the Fund (i.e. transfer to OPEB)

With respect to the census information request, as noted above please do not include any information that could be interpreted as Protected Health Information (PHI) as defined by the Health Insurance Portability and Accountability Act (HIPAA).

Please provide the data in Excel format.