State Employees Health Plan Task Force
Buena Vista, Bucks Library, New Castle, Delaware 19720
Thursday, September 24, 2015

The State Employees Health Plan Task Force Committee met on September 24, 2015, at Buena Vista, Bucks Library in New Castle, DE 19720. The following Committee members and guests were present:

Ann Visalli, Director, OMB
Brenda Lakeman, Director, OMB, SBO
Faith Rentz, Deputy Director, OMB, SBO
Lisa Porter, OMB, SBO
Tim Barchak, NEA
Michael Begatto, AFSCME
Tom Brackin, DSTA
David Craik, Pension Office
Martha Dennison, AFSCME
Jim DiGuiseppe, Willis
Jessica Eisenbrey, OMB
Patty Friedman, Aon Hewitt Consulting
Debra Gerardi, OMB
Darcell Griffith, Univ of DE
Daniel Hamilton, Office of Auditors Accounts
Cheryl Heik, Cozen O'Connor
Chris Hudson, Univ of DE
Katherine Impellizzeri, Aetna
Harvey Kenton, Representative
Andrew Kerber, DOJ
Geoff Klopp, COAD
Tom LaPenta, Univ of DE
Dave Lawson, Senate
Maureen Ludlam, DHSS
Renata Manning, Highmark
Omar Masood, OST
Brian Maxwell, OMB
Harris McDowell, Senate
Mike Morfe, Aon Hewitt Consulting
Mike Morton, CGO
Jennifer Mossman, Highmark DE
Evelyn Nestlerode, AOC
Bill Oberle, DSTA
Pamela Price, Highmark DE
Kimberly Reinagel-Nietubiez, CGO
Paul Reynolds, DOI
Scott Ridge, RDS
Paula Roy, Roy Associates
Roger Roy, Teledoc
Ken Simpler, OST
Wayne Smith, DHA
Jeff Taschner, DSEA
Chris Ulrich, Univ of DE
Jennifer Vaughn, DOI
Tom Weatherup, Truven Health
Karen Weldin Stewart, DOI
Kim Williams, Representative

Introductions/Sign In
Director Visalli called the meeting to order at 10:03 a.m. Everyone was reminded to sign in. Introductions were given around the room.

Approval of Minutes
Director Visalli requested a motion to approve the minutes from the September 9, 2015 Task Force meeting. Mr. Begatto made the motion and Treasurer Simpler seconded the motion. Upon unanimous voice vote the minutes were approved.

Trend Driver Analysis – Truven – Tom Weatherup
Mr. Weatherup of Truven Health Analytics presented the Trend Driver Analysis for the State of Delaware – Active & Early Retirees. These parameters are based on Active and Early Retiree population (unless otherwise specified) for the time periods of Prior Year (PRY) reflects claims incurred May 2013 through April 2014, paid through July 2014. Current Rolling Year (CRY) reflecting claims incurred May 2014 through April 2015, paid through July 2014. High cost claimants are defined as members who incurred $100K or more in medical and drug during the time period. Normative comparisons were made to the MarketScan TM database unless otherwise specified. Health risk scores were calculated using DxCG's diagnostic cost groupings, which use demographics and diagnostic information to assess risk. The State of Delaware

experienced a 1% increase in employee plan enrollment. The demographic make-up of the active population remained stable. The estimate of the health risk of this population has increased quite a bit. This risk is measured using a licensed tool called DCG from a company called Verisk that calculates the risk of the population versus the whole U.S. average. The whole U.S. average is set at 100, so the risk for the employees for the prior period was 134 or 34% higher than the average and has grown to 161 or 61% with a 20% growth in the risk of the population. Risks are measured by looking at the diagnosis on the claims and not by the procedures done to employees. There has been a continual increase in the risk of the population which is a big issue.

On a per employee basis, State of Delaware net payments increased 9% in the current year compared to the prior period. Medical showed a 7% increase and Prescription Drug claims increased 13%. The State of Delaware has higher cost, use and price rates than the Norm for all metrics except Outpatient Services per member. The Allowed Amount per Admit continues to increase year-over-year. State of Delaware's drug costs are significantly above the norm due to both higher drug price and use.

Chronic health conditions drive the State of Delaware's comparative high cost that include spending on Osteoarthritis and Coronary Artery Disease which exceeds the next seven conditions combined. Nearly all of the costs associated with Chronic Conditions are related to overweight and inactivity.

Mr. Taschner asked what is the aggregate of the chronic conditions (slide 5) that is paid out each year out of the $700M? This is explained in later slides.

Senator McDowell questioned if the chronic condition cost is relevant to growth or to a long period of time? Mr. Weatherup stated it is current period total dollars. Osteoarthritis is the culprit in this period.

The Statewide Benefits population reflects a higher prevalence of every chronic condition compared to the Delaware state average and is measured per patient per 1,000 members. Osteoarthritis has a 20% higher prevalence. All of these are double-digit compared to the State as a whole or 10% or more above the state average. The State of Delaware was rated in the CDC 9.9 per 100 which is amongst the worst in all the States. In high risk/poor health, the State of Delaware was 21% higher than in New Jersey and 8% higher than in Maryland.

State of Delaware net payments increased $1,038 per employee in the current year. More than half came from high cost claimants (HCC). Outpatient use and prescription drug price are the biggest factors. The cost sharing and family size had very little impact. HCC are defined as any member that incurred $100K in claims in the year. HCC prevalence rose 21% (to 6.3 HCCs per 1,000 members), driving the trend, causing the shortfall in funds. Net payments per HCC increased 4% (to $205,150). Chronic conditions accounted for 61% of HCC medical net payments in the CRY. The top five medical conditions for HCC were similar in both years except for CAD and Cerebrovascular disease.

Director Visalli reminded the committee if 4% was the underlying trend, we are at 9% this period and were at 7% the prior year period. The trend went from 4% to 7% to 9% as shown and not 4% to 9%.

The high cost claimants year-to-year show HCCs per 1,000 members and in different categories with HCCs in both years, only in given year and not the prior year or in the prior year and not in current year. HCC this year who weren't continuously enrolled in the prior year, shows the average person in this group had claimants of $269K. In the prior year, they only incurred $31K which is a big difference and big issue. Of the 498 HCC in the PRY, 27% remained high cost in CRY. Of the 607 HCC in the CRY, 22% were also high cost in the PRY. Slide 11. The new growth in the HCC is a third split among employees, spouses and dependents.

Mr. Taschner asked several clarifying questions with regards to Slide 11 and requested additional detail on the actual dollar amount attributed to HCCs in the CRY and not in the PRY. Mr. Weatherup explained that when you look at the

whole group of HCCs for the year, they're driving half of the trend. That's what is driving the change in the trend from 4% to 9% both in terms of the number of HCCs and the total costs attributed to HCCs.

Senator McDowell inquired as to what is the whole real growth. Mr. Weatherup answered that the HCCs represented more than half of the total increase.

HCCs continue from year to year with chronic conditions. Both repeat HCCs and new HCCs in the CRY who had been enrolled for the PRY had 63% of their CRY medical net payment for chronic conditions. New HCCs in the CRY who had not been enrolled the entire PRY had less than half (41%) of their CRY medical costs for chronic conditions. A new entrance and big hit in the CRY was 25% or $3.9M for newborns.

Treasurer Simpler reiterated if comparing people with both years versus one year, the HCCs in both years didn't show much difference, pretty stable around $209K to $202K. Then there's a big jump from $223 to $430K with a small group of people. Mr. Morfe responded that the average cost of HCCs is not the issue, it's the number of HCCs. The volume of HCCs went up 21% but the cost per HCC went up only 4%. What is relevant is the volume.

The primary drivers of the 3% increase in inpatient (IP) price per admission are HCCs accounting for one percentage point of the IP price increase. After holding the HCCs stable, surgical admissions become the primary driver of the IP price increase, followed by substance abuse went up to 42% with a higher trend than surgical admissions but a lower volume. Utilization (70 admits per 1,000 members) shows Maternity went up 10%, MHSA went down 6%. Surgical was flat, and Medical admissions were 3%. Overall a 3% increase in admissions.

Outpatient utilization shows a 3% increase in trend with office and PT/OT/ST/CT services accounting for 2% increase of the overall 3% increase. Outpatient price shows surgery and office services accounted for one percentage point of the 2% outpatient price trend. Surgery price increased 4%, driven in part by HCC.

Prescription Drugs had a 10% increase with the primary drivers of HCCs using very expensive medicines. If HCCs had remained stable, the overall Rx price increase would have been 5% instead of 10%. The use of very expensive medicines, is creating HCCs. Overall prescription drug price was impacted by increased generic utilization in the CRY with 78% of days supply, up three percentage points from the PRY.

Director Visalli affirmed her counterparts in the country are facing similar issues and asked if possible to differentiate how much of this is market driven and if any of it is unique to our population. Mr. Weatherup responded it's happening across the industry as one of his customers is facing a 16% increase. Utilization looks good as retail generic increased 70%.

HCCs and Prescription Drugs are the big drivers.

Treasurer Simpler said in terms of these HCCs, we are only looking at one year of rolling data and know the drug prices are a problem, but looking at our own HCCs, this data shows a prevalence of folks remaining high cost is lower than people just having an event for one year in our plan. It is mentioned there is data going back four years, if you averaged that data would we still see a trend of HCCs? Mr. Weatherup stated this data is based on a three year trend with 2013, 2014 and 2015 and it showed increases between the years. The first year a spike appeared was in the 2013 to 2014 period.

The key findings and opportunities discovered that if you don't take the HCCs into account, the Prescription Drug price is the biggest driver of the trend. Drug cost for Retail Brand and Mail Brand was significantly high and accounted for 72% of the Prescription Allowed Amounts in CRY. We need to investigate opportunities to increase Generic and Mail Order use and a review of place of service for specialty drugs for opportunities to lower cost service locations.

The Medicare Retirees Trend Driver Analysis shows that the State of Delaware experienced a 5% increase in plan enrollment and the demographic make-up of this population remained stable. The 2013 health risk was significantly higher that the DCG nationwide average indicating a higher than average illness burden in the State of Delaware population and continued to increase in 2014. The net payments increased 17% in the CRY and Prescription drugs increased 19% from the PRY and inpatient care increased 27% in the CRY. Prescription Drugs make up 67% of the plan and is a much bigger issue in the Medicare population than medical and growing fast.

HCCs are not as much of an issue with the Medicare population as with the Actives and Early Retirees. Inpatient Acute Care price actually declined 2%. The HCC accounted for 1.9% of the inpatient price decrease. Inpatient utilization increased 3% with long term care costs increasing substantially. Overall net payments increased from $5.3 to $9.4M. Outpatient utilization had a 4% increase which is desired versus inpatient utilization. The primary drivers of the 16% increase in prescription drug price include Brand fills accounting for 70% of Rx allowed amount in the CRY. Key findings reveal the primary driver of trend for the State of Delaware Medicare Retiree is drug cost with claims accounting for 67% of CRY spend, a 17% increase from the PRY.

Treasurer Simpler asked just about how much of the HCCs is prescription drug driving this trend. The response was Specialty Pharmacy is expensive and some drugs are infused that don't go through the drug program and is billed through the medical plan so it is not all captured in the prescription drug program.

Senator McDowell inquired where the costs for the new Hepatitis C drug falls and it was stated it is captured in the prescription drug program. The Senator then asked what the increase is in costs for this medication. Director Visalli stated that within the HCCs there are also drugs that may show up in either medical or the prescription drug programs. Senator McDowell asked if there are reasons why the State of Delaware employees are contracting Hepatitis C and requiring this drug and can we know? Ms. Lakeman stated the Hep C drug was new so there was a huge uptake for people who have this illness and now are taking this medication. We do have the numbers from prior years that will show this increase. Senator McDowell said the percentages and increases would be interesting to know.

Mr. Begatto asked if we can get information on which drugs are being purchased and utilized that are causing these high increases.

Trend History and Benchmark - Aon Presentation – Mike Morfe
Responding to September 9 requests,

Detail on overall spending, plan sponsor trends with like circumstances.
The latest figures from the Kaiser Family Foundation analysis of Quarterly Services Survey (QSS) conducted by the U.S. Census Bureau includes the vast majority of the health care spending. Hospital spending increased 9.2% between 1Q14 and 1Q15. The number of hospital days rose 3.5% and the number of discharges rose 4% over the period while price and intensity made up the remainder. There is a lot of volatility in the healthcare spending world.

The Medical and Prescription Drug historical and emerging trends reveal an uptick in spending for the State of New Jersey, State of New York as well with a large Delaware employer showing lower trends in the past than expected to be in the future with much of this driven by prescription drugs.

The Benchmark industry group is based on 46 employers offering 102 various benefit plans with the report generated September 18, 2015 and Aon continually refreshes the plan data.

Mr. Oberle and Mr. Begatto requested where the 46 benchmark employers were from demographically. Mr. Morfe explained these employers may be headquartered in one state with offices in other states.

Plan Premiums Benchmarking report reveal employee contributions for the Public Sector at 17%, All Groups at 22% with the highest for State of Delaware at 13% in single employee contributions. Similar numbers were shown for the family employee contributions.

Deductibles for the State's plans are compared with the Public Sector and All Groups. Most of the deductible in the CDH plan is covered by the $1250 (EE) and $2500 (family) HRA which pays first. The deductibles for the Public Sector and Groups are going to be blended similarly to the First State Basic Plan and plans that look like the CDH plan.

Mr. Taschner asked for the individual breakdown or component parts of the Public Sector and All Groups to the plans similar to the State's First State Basic Plan and CDH plans. Ann Visalli offered that if other committee members have source data available, they are welcome to share with members.

The HRA Employer Contributions that help pay for the health plans are $1250 and $2500 for the State. The HRA plan became effective in 2012 with the CDH and is growing in popularity. The State does not offer a Health Savings Account (HSA) plan but does offer a Flexible Spending Account (FSA) which has over 5,000 members participating.

Representative Williams asked with the Flexible Savings, if the employee does not use the money, they will lose it, correct? Ms. Lakeman responded there is a grace period after the end of the year till March 15th that the employee can incur claims for the prior year but if they do not incur claims by March 15th, they do forfeit the funds which the State does use to pay the administrative fees of the FSA plan. Unlike the FSA account, once the money goes into the HSA account, it belongs to the member and it is not forfeited. The HSA can carry on through retirement.

Senator McDowell asked for any details if the State instituted HSA and how that will impact costs. Mr. Morfe said the majority of people are in the PPO program but if forced into an active enrollment with different plan options that may result in a lot of activity with an HSA plan depending on what the other options were. If offering as a number six or seven option, limited or low activity would probably be the result.

Trends reported by external surveys reveal more than 84% (33 of the 39) offer a PPO plan. The average monthly premium for employee only coverage and family coverage paid by the employer was 87% and 77% respectively. The PWC 2014 Touchstone Survey reported offering plans with narrow networks, investing wellness programs, contracting with centers of excellence and participating in private exchanges are steps taken by employers to reduce health care costs. 44% of employers across all industries are considering high deductible plans. Employers are increasing employee contributions for dependent coverage. In 2013, 19 States offered plans with a deductible of at least $1500 for employee coverage, an increase from 16 States in 2011.

Mr. Oberle asked what types of employers respond to this survey. Mr. Morfe explained it tends to be employers with greater than 500 employees, geographically diverse and offering a wide preponderance of plans. Mr. Oberle stated it may have more meaning if we're looking at public sector regional employers in terms of a comparison. Director Visalli stated that to the extent we can we will provide public sector only data and it is also important to separate public from private and compare public to public.

Key observations from the Aon Health Care survey of Plan Sponsors are many employers are waiting to take action on major changes to their health strategy – looking first to their peers for guidance. To reduce longer-term trend, employers are planning strategic changes on how they fund health benefits. Moving to high-deductible plans remains a primary design strategy to reduce cost and engage participants to improve health decisions. Options to review are redesign plans and review premium cost-sharing structure.

Director Visalli stated at some point we need to start moving directionally towards what we have consensus on or don't have consensus on and within the scope of the epilogue. If we need to go into more depth of particular areas, the agenda will be set to provide that information.

Commissioner Stewart stated in reference to the high cost of HCCs, we don't know if these HCCs are going to continue through the year so we don't know if it's a 5 year trend or just for the year.

Senator McDowell stated we will have to discover some changes or we will be faced with adding more funding as was required when $50M was added to the FY16 budget plus another amount of money put on the employees as copays. We will be faced with the same thing this year if we don't bring some change. We need to investigate the HSA which could be used as a health care mechanism and a financial mechanism. More detail on these areas will be provided.

Ms. Lakeman announced that four Public Testimony meetings were held at different sites in Dover, Georgetown, Wilmington and Newark. Most attendees and speakers were employees along with a few vendors. Information is posted on the Task Force website. Mr. Begatto stated he attended three of the four Public Testimony meetings and reported the attendance was small but the message was very clear to provide the comparisons of salaries versus benefits and the need for the Task Force to hear this message. There were vendors that attended that said they could save the State money. An audit would be a reasonable request. Chiropractors also attended the meeting stating they could save on surgical for the State where other options may not be best procedures for our plan. A former legislature attended representing Teledoc talked about savings. We need to make sure where we are spending and that we are spending properly.

Follow-ups from the previous Task Force meeting are included. Emails were sent from the SBO office with enrollment questions and Centers of Excellence. At the next meeting, we are planning three presentations on the Delaware Center for Health Innovation regarding Statewide Payment Reform and Population Health to help the committee understand the statewide initiative followed by a presentation from Highmark and Aetna which will discuss movement they are making on payment reform. We are still trying to get more information on the Medicaid rates.

Other Business

Mr. Taschner commented there are two documents prepared by Tim Barchak, Senior Policy Analyst regarding Centers of Excellence and other efforts to look at provider's charges. These are SWU (State Workers United) approved and will be sent to the committee to review between now and the next meeting.

Mr. Begatto expressed concern on page 17 of the Truven presentation with the outpatient utilization increase of 3% in office visits and raised the issue of revisits to doctors for sick notes. Mr. Taschner reemphasized this does have an impact on the doctor visits and utilization as captured in the presentation.

The next Task Force meeting is scheduled for October 8, 2015 at 1:00pm in the Tatnall Building, Conference Room 112 in Dover. The meeting was adjourned at 12:10 p.m.

Respectfully submitted,
Lisa Porter
Executive Secretary
Statewide Benefits Office, OMB