State Employees Health Plan Task Force
Buena Vista, Buck Library, New Castle, Delaware 19720
Thursday, October 22, 2015

The State Employees Health Plan Task Force Committee met on October 22, 2015, at the Buena Vista, Buck 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
Michael Begatto, AFSCME
Tom Brackin, DSTA
Andrew Brancati, Highmark
Lisa Carmean, City of Milford
David Craik, Pension Office
James Dawson, WDDE
David Deputy, Representative
Hardy Drane, DOI
Jessica Eisenbrey, OMB
Peg Eitl, Highmark
Debra Gerardi, OMB
Darcell Griffith, Univ of DE
Cheryl Herk, Cozen O'Connor
JJ Johnson, Representative
Harvey Kenton, Representative
Andrew Kerber, DOJ
Gary Kirchhof, Highmark
Geoff Klopp, COAD
Dave Lawson, Senate
Omar Masood, OST
Brian Maxwell, OMB
Harris McDowell, Senate
Mike Morfe, Aon Hewitt Consulting
Mike North, Aetna
Evelyn Nestlerode, AOC
Bill Oberle, DSTA
Pamela Price, Highmark
Kimberly Reinagel-Nietubicz, CGO
Paul Reynolds, DOI
Roger Roy, Teledoc
Paula Roy, DCSN
Ken Simpler, OST
Wayne Smith, DE Healthcare Assn.
Jeff Taschner, DSEA
Chris Ulrich, Univ of DE
Karen Weldin Stewart, DOI

Introductions/Sign In
Director Visalli called the meeting to order at 9:05 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 October 8, 2015 Task Force meeting. Representative Johnson made the motion and Commissioner Stewart seconded the motion. The motion was passed. It was noted Senator McDowell did not vote.

Mr. Taschner expressed concern and the importance of how this Committee spends today's time along with the remaining meetings and made a few suggestions. He stated that there has been a rapid increase in spending of $3 medical/$1 prescription to $3 medical/$2 prescription. Truven showed this is the result of an increase in prescription costs and not usage as more members are being directed from brand to generic along with more use of retail 90 and mail order. The additional review of High Cost Claimants (HCC) showed an increase in the number. The last meeting with Aetna and Highmark showed our hospital costs are significantly higher compared to other markets. It is a struggle to see how today's agenda addresses these cost drivers identified by the experts brought before us. Receiving the presentations prior to each meeting is incredibly helpful and the third concern is to manage the meeting time better to address the follow-up items.

Director Visalli reminded committee members to submit items of interest to include on the agenda.

Senator McDowell shared similar concerns and realizes this is an enormous subject. He expressed concerns over the sudden unanticipated increase last year that was shocking and that it is still not known if it is an ongoing trend. The State Treasurer has asked on at least three occasions if we could get to the

business of seeing what has to be done. Senator McDowell stated that on at least three occasions, he has requested the need to have an in-depth, thorough, independent audit of the system to see what happened and has yet to see this done. Additionally, he expressed frustration that the Task Force has not had a chance to discuss how to issue a report or vote on a report to submit to the Legislature. Instead, time has been spent getting information from people who are in the system and who may be or may not be a part of the problem. Senator McDowell acknowledged that this is a large area and hard to get your arms around it in a comprehensive way and expressed concern that the group is being led down a path where the Task Force will be presented with some sort of conclusion that says the culprit has not been identified.

Director Visalli responded the audit status will be discussed and acknowledged there is a significant problem for FY17 and hopes this committee will have ideas to both balance the FY17 budget and suggest changes to impact the long term and how health care is consumed.

Ms. Lakeman commented that the Statewide Benefits Office (SBO) expects to have the draft request for proposal (RFP) tomorrow from Segal to release in the next week to ten days. The draft RFP will be posted on the Government Support Services (GSS) site for two weeks to allow for individuals and vendors to comment on the content for SBO to review and determine if any suggestions or questions should be incorporated into the RFP. It will then be released as final for bidding. Contract award is expected in January. It was noted that this is an aggressive time frame as it generally takes five months to complete a procurement.

The Treasurer suggested to share with the committee the core scope of services and the evaluation criteria in the draft RFP when it becomes available. It was agreed the draft RFP could be sent out to members and posted on the GSS website. It is estimated that a thorough audit of both the medical and prescription plans will be completed with reports issued in June 2016.

Mr. Klopp expressed his understanding that this is a difficult and delicate situation. As we look at these numbers and the breakdown, he reminded everyone that for every $25M of healthcare cost that is shifted to the State employees and retirees, this equates to about a 2% pay cut. With the recent changes in effect, look at the cumulative damage that we are attempting to instill upon our employees and retirees without any consequential pay raises to offset these costs. Mr. Klopp asked members to consider this throughout the process.

Director Visalli responded that a 1% pay raise costs the State approximately $15M so actually a 2% pay cut would be about $30M. Senator McDowell said last year approximately $50M or 3.25% pay raise was added to the budget to fund healthcare increases with additional costs on to the employees. If there is a need for a $50M increase this year and the decision is to lay this on State employees, this is an unacceptable approach. He shared how one of the State's consultants suggested a different and refreshing way to provide services and that a similar consideration should be given to RFPs for health insurers. Ms. Lakeman commented that SBO will be going to bid in CY2016 as FY17 is the last contract year with Highmark and Aetna. The bid is typically structured to receive pricing on a self-insured and fully insured basis to determine which is the most cost effective. One of the exhibits sent out to the Task Force showed the costs would be significantly higher if we contracted on a fully insured basis as margin is built into fully insured premiums to protect against unexpected increases in claims. Senator McDowell stated last year, if we were insured by an insurance company, we would not have had to add any money to the budget nor pass additional costs on to the State employees; the insurance company would have had to pay. Ms. Lakeman explained that insurers recoup losses in the following year as fully insured premiums

rates are set annually based on the plan's experience. The State has been able to save money being self-insured as the State holds the risk and has had several years where the premium rates remained flat. Commissioner Stewart mentioned Stop Loss insurance. Ms. Lakeman commented on the stop loss analysis distributed to the Task Force and how it illustrated that in certain years the State would have saved money purchasing stop loss coverage at the $250,000 deductible level assuming the State was issued the coverage at the low end of the premium range. Based on the recent experience, it is likely stop loss coverage, if issued to the State, would be much higher. The analysis illustrated that at higher deductible levels of $500,000 and $750,000, the State would pay more in stop loss premium than paying the actual claims in excess of both thresholds. Over the long haul the analysis did not necessarily show it to be worthwhile for a large group like the State.

Treasurer Simpler shared his hope that a full evaluation of the medical and prescription claims and administration would result in savings that could mitigate the FY17 increase; however, it appears that will not be the case and asked if the timeline could be reduced. Ms. Lakeman explained that the reviews would not be conducted separately; however, simultaneously to move through the process as quickly as possible.

Express Scripts is willing to attend the next meeting and is asking for what the committee would like to see. They can provide information related to the cost drivers which are primarily on the specialty side. The Treasurer expressed interest in understanding what the money is being spent on in the areas of medical and prescription benefits. He is interested in seeing the vendors address short term solutions that can be accomplished through claims reviews and plan design but also options that reduce consumption and overall costs as opposed to simply shifting costs. Ms. Lakeman said the Highmark presentation may address some concerns related to the medical provider side.

Mr. Oberle commented that he was glad to see discussion on today's agenda related to reimbursement rates. He would prefer to focus on how to contain costs and regulatory schemes that would put us in a better posture to negotiate with the healthcare providers as opposed to a third party administrator negotiating rates on behalf of the State Group Health Program. Highmark and Aetna pointed out Delaware hospital costs being 25% higher than surrounding states. To contain costs moving forward, he suggests looking at a regulatory scheme that brings us more in line with surrounding states. Whether this is through the Insurance Commissioner's Office or third party administrator to negotiate or challenge unfair charges. Mr. Oberle also inquired as to how we get groups before the Task Force that may possess a solution to the current dilemma without creating a conflict of interest. Mr. Kerber, Deputy Attorney General, responded that there is an issue with a significant overlap of Task Force members who are also SEBC members which could expose those vendors to significant risk if presenting to the Task Force and later awarded business by the SEBC as a result of a procurement. Other bidders for the business procured would not have had the same opportunity. Mr. Kerber will consult further with the Department of Justice.

It was noted that Highmark and Aetna already have contracts with the State when it was questioned why they were able to present before the Task Force. Ms. Lakeman added that the SBO typically meets with vendors rather than the SEBC. If their services or programs are worthwhile, as appropriate, the SBO brings the information before the SEBC to consider as part of the State Group Health Program. If the SEBC prefers from now forward that they would want every product to be brought to them but not mention a vendor, the SBO could give a generalization and upon approval by the SEBC, pursue a RFP; or if we want to somehow modify the current process to accommodate these requests, that can be discussed as well.

Committee discussion furthered on the topics of procurement process and RFP. Senator McDowell shared a few scenarios with the committee and suggested a review of the State's procurement process.

Representative Johnson stated if our costs are 25% higher than surrounding states, can the Task Force look at the surrounding states and see how they keep their costs down. Mr. Oberle asked the Insurance Commissioner if the other States regulatory schemes currently in place differ from the State's and it was noted that Delaware does not have any in place. West Virginia and Maryland were looked at as examples of States that regulate hospital and provider rates to hold down costs.

Highmark – (handout) Gary Kirchhof, Director Provider Contracting

Concern was again raised by members of the Task Force about the impact of Highmark's presentation if information presented led to a procurement and if that would create a conflict. Ms. Lakeman stated Highmark is going to put forth some recommendations related to provider contracting which is a responsibility as our current vendor. Director Visalli mentioned the DAG is here and will keep track of any potential conflict.

Mr. Kirchhof stated the information to be presented will inform the Task Force of what has been done to address the cost curve concern. Hospital costs are the highest amongst the medical costs. This has been realized and Highmark has been working the last few years to change that. Mr. Taschner asked for a percentage or breakdown of the hospital costs out of the medical spend along with the amount that goes elsewhere to physicians and other medical providers.

In Delaware, significant ownership is dominated by a single hospital or system in each region where as in other markets, there is competition and that drives down costs. Over the years, hospital acquisitions of physician practices have accelerated which further changes the dynamic and drives up the total reimbursement being received by hospitals. Hospital payments per casemix are significantly higher in Delaware than other Highmark markets based on quality, costs and access. Medicaid payments to Delaware hospitals for inpatient services are 56% of commercial payments for similar services.

Highmark is converting hospital reimbursement from fee-for-service to a DRG-based model and is targeting to have migrated 80% of inpatient claims activity to a DRG reimbursement by the end of 2016. DRG-based contracts have fixed annual increases based on quality performance. Highmark has converted many high volume services (outpatient) from percentage of charges to fixed fee or case rates at most hospitals. Products are being modified to provide incentives so members choose high quality cost alternatives. Highmark is contracted with all hospitals and nearly all providers and is the largest payer in Delaware. Everyone in the Delaware market is experiencing increased costs.

Analysis shows the Delaware hospitals allowed amounts as a percentage of Central Pennsylvania hospital average and that over time the DRG-based reimbursement hospitals to be lower than those hospitals that have not migrated to DRG-based. A similar analysis was shown comparing Delaware hospitals with a West Virginia hospital average.

If all outpatient lab and imaging services shifted to a freestanding facility for State of Delaware members, the State would have annual savings of $5.7M.

Discussion occurred about how members have choices and in the current environment most go where their doctor tells them versus shopping for services. Director Visalli shared that a specific proposal to encourage the use of freestanding lab and imaging services was discussed in depth by the SEBC as a

method in finding savings and helping employees and retirees be better consumers. More hospitals are taking ownership of freestanding facilities so there is a need for differential pricing. Highmark has LabCorp and Aetna has Quest as the preferred vendors for lab services and have contracted with these vendors for lower cost lab services; however, if a member goes to a non-provider lab or hospital out-patient for lab work, it is costing the State Group Health Program more money.

Treasurer Simpler asked if Delaware's 25% percent higher costs are a result of the lack of competition. Is data available on what the composition of the different payers look like? Does Delaware have a significant higher share of Medicaid or Medicare people? The demographic mix of payers for other regions was not known but it was stated that the managed care networks lose money on the Medicaid population and may break even on the Medicare population. Commissioner Stewart stated West Virginia would have lower prices as they have a scheme for fixed rates in place like Maryland has. Legislation would be required to implement this in Delaware.

Mr. Klopp said the neighboring states are controlling their costs through legislation and Delaware seems to be geographically monopolized by a couple different providers. Delaware does not have a regulatory framework for pricing by hospitals and would have to designate who has that authority and how it would work. It was asked who in those states has authority? Commissioner Stewart responded those states have an independent commission where the Governor in those states (WV & MD) appoints members to their commissions. Pennsylvania does not have a regulated framework which may be due to a larger community of providers. Highmark stated they are working with the high cost hospitals to move to DRG-based reimbursement. An immediate reduction would have implications for members that could be disruptive in the community, sacrificing quality with drastic changes would have impact on these facilities with employment, services and other factors. DRG stands for Diagnosis Related Grouping.

Commercial consists of Highmark Delaware (self-insured & fully insured), State of Delaware and private companies. DHOP is the Medicaid program that Highmark offers through contract with Medicaid in Delaware. The DE Medicaid (green) represents CMS Medicaid rates for Delaware. Highmark is allowing a higher rate than what CMS actually proposes. It was asked if the DHOP illustration assumes profit margin to Highmark. Highmark responded it is more of a social mission and it is not yet known if Highmark will even break even administering benefits to the Delaware Medicaid population. The Medicaid market is not believed to be self-sufficient across the nation and in other regions as well. The point of the slide was to share there are hospitals on both ends of the spectrum and Highmark's efforts to move towards DRG & APC are really important and having impact.

Senator McDowell stated it would be very interesting to see dollars in the same graph. Highmark stated sharing that much information was a concern but did want to answer the questions presented by the Task Force. Director Visalli reminded the Task Force that the State Group Health Program hospital expenditure information was supplied. Mr. Taschner asked if it would be possible to get a similar breakdown of the other States data to suggest anything about the impact of the regulatory scheme. It was noted (slide 4) that Hospitals A & D must be those to be converted to DRG by 2016. Highmark was asked to provide a breakdown on Hospitals A-F of the percentage of in patient claims each facility represents. Is it possible to get comparative data for Hospitals B, C, E & F to see how the agreement to the DRG approach has lowered costs since in place; and what might the State anticipate should Hospitals A & D come in line? Representative Johnson commented on another dynamic is the amount of hospitals or providers that we have in the State of Delaware and if there are there enough for the population as you don't see hospitals advertised.

Summary concluded that Highmark is the largest payer in the State and has been around for more than 80 years. Highmark will continue to use that leverage to pursue contract negotiations on behalf of members and clients to make changes. There are opportunities to incorporate benefit design changes that incent member behavior to utilize more cost efficient providers where possible. Use of incentives, penalties, Reference Based Pricing (RBP) and rewards to enhance member education efforts around cost drivers. RBP is an allowable set in the benefit level for specific type of service and the benefit level drives what will become the payment to the provider; any difference or delta between the contract price with the provider and the RBP becomes the member's liability. This type of model requires extensive member education. It was asked if there are any recommendations to incent or change provider's behavior versus only the members? Highmark responded there absolutely are and shared how Highmark has recently started a partnership with an independent ACO (Accountable Care Organization) that includes an incentive to drive higher quality and lower the cost curve through a gain share arrangement. To the extent the ACO can beat the rest of the market in meeting cost and quality measures, they will receive a portion of the savings. Mr. Taschner expressed as to why this concept was not included in the Highmark presentation. Director Visalli responded the concept was previously covered in The Center for Health Innovation presentation.

Highmark is willing to continue to push hospitals and providers to negotiate more aggressive reimbursement rates; however, past attempts have not proved successful and pressing too hard exposes risk to the network should these providers decide not to contract. There are real and tangible outcomes to these negotiations. Another option is to have this Task Force recommend to the Legislature that the State impose legislation similar to WV and restrict the cost of those services or put a price tag on those services; if we don't have competition and can't negotiate, then we have to legislate.

Commissioner Stewart stated she has been meeting with a number of insurance companies to invite them into Delaware to write business to create more competition on the health care side. These companies recognize the leverage Highmark has with the hospitals and the limited movement that has occurred and feel that it is not competitive for them to do business in Delaware.

Treasurer Simpler stated since we do not know if the market in Delaware is radically different than the markets in West Virginia or Maryland, it would be helpful to get an understanding of what these others States are looking at in their payer base so we can determine what leverage we would choose to use. Director Visalli stated there are consequences to regulate a price ceiling. Mr. Oberle requested to have someone from the Maryland Commission come before this committee and explain how they operate and what their experience has been.

Director Visalli suggested the committee take a five minute break. There was no objection from the Task Force.

Aon Hewitt Consulting – Mr. Mike Morfe

Long term cost projections of the GHIP plan at 9% trend place total costs for the State Group Health Program at over $1 billion in FY2020. Projected expenses for FY17 are $853M with a $130M shortfall with no additional increase in State or employee/retiree contributions. As well, premium cost sharing changes and other cost shifting does not mitigate the excise tax expected to hit beginning in FY18.

At the October 8th meeting, four dimensions of potential changes were introduced and two of these will be discussed today, redesign plans/plan design and premium cost-sharing structure. Some options can be implemented together and others are considered to be mutually exclusive. Implementation or action on

any of these options would be the responsibility of the SEBC, the Legislature and/or parties external to State Government such as payers, providers and participants who choose to utilize their health benefits differently.

The meeting today will focus on the Active and Non-Medicare Retiree plan. The Medicare Primary Retiree options will be discussed at the November 5th meeting. Details of the projected plan cost of $853M in 2017 are $509.2 Active, $120.5M Non-Medicare Retiree which totals $710.7M with another $142.0M projected for the Medicare Primary Retiree group. Actuarial Value is a health care industry term used to represent percentage of total average costs for covered benefits that a plan will cover. Actuarial Value is not tied to a predetermined plan design. Four primary levels are: 60% bronze, 70% silver, 80% gold and 90% platinum. Current plans have actuarial values with PPO and HMO 90 to 91% (platinum), CDH and FSB 86 to 87% (gold). State Share is approximately 80% Actuarial Value. Reducing the actuarial values has an estimated value/savings for FY17: 5% = $35.5M, 10% = $71.0M or 15% = $106.6M.

Discussion today will focus primarily on shifting costs through the plan design or contributions.

Five options were presented for the redesign of the plans:

- two CDH plans with a high and low option;
- two CDH plans with a gated design which allows only employees who perform certain health management task to enroll in high option;
- two managed care plans with a HMO platform and PCP focus on care coordination and pay for value;
- trend mitigation of current plans whereby cost sharing is increased to adjust actuarial value;
- active exchange (private) group basis which utilizes a private exchange with group plans.

The concept of each option was presented with the values each concept would achieve and challenges associated with implementation. Legislation will be required for some of these options. The details are laid out in the presentation. Clarifying questions were asked of the Task Force members throughout the presentation. The Treasurer indicated that it would be helpful to quantify the impact that CDH and managed care plans might have on the consumption of healthcare services. Mr. Morfe indicated that studies suggest 5% savings is achieved through better behaviors and consumption in these types of plans.

Mr. Oberle expressed concerns that not every consumer is savvy and might not know how to use these types of plans or the consumerism tools. Mr. Begatto asked how do we explain and educate members on these costs and that their healthcare won't be affected at all? Ms. Lakeman responded that the SBO did have Employee Education meetings before open enrollment and the vendors came and talked about their transparency tools. Attendance at the meetings was low.

Regarding the concept of a private exchange, Mr. Oberle commented that the market was dominated by Highmark and Aetna and that it may be difficult to find more insurers to come in and compete for the business. Mr. Morfe stated that more insurers would increase competition; however, it is difficult for an insurer to do that in Delaware considering the small number of players.

The remainder of Mr. Morfe's presentation will be discussed at the November 5, 2015 meeting. Ms. Lakeman reiterated if there are specific follow-ups that a Task Force member is interested in concentrating on at the next meeting to please notify her. It was noted to have some of the hospital providers come before this committee. Mr. Oberle expressed the need to explore how to get other vendors to present without creating a conflict in the event of a procurement. Ms. Lakeman asked the Task

Force members to forward interested vendors with their topic/area of interest (no vendor name needed) and the length of time needed to present and these requests would be considered for inclusion on the agenda for the next meeting.

Senator McDowell asked if Aon's presentation today showed all of the options and could any actions like bringing in vendors to speak have an impact? Mr. Morfe responded that Aon tried to break the ideas into four broad categories with the top five plan design options and believes there are other concepts that could be included. As well, other options would not work due to the limitation of providers and lack of competition.

Senator Lawson stated that it appeared legislation might be where the Task Force is headed in terms of recommendations and expressed concern over the amount of content being presented. He also stated the need to get all of the stakeholders at the table.

Mr. Oberle thanked Highmark and Aetna for their transparency and that it has been extremely helpful in beginning to define where the problem really is and will help dramatically moving forward.

Ms. Lakeman asked for a motion to adjourn. Representative Johnson made the motion and Representative Kenton seconded it. The meeting adjourned at 12:00 p.m.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office, OMB

The next Task Force meeting is scheduled for November 5, 2015 from 9:00 a.m. to 4:00 p.m. at Buena Vista, Bucks Library in New Castle. Lunch will be provided for the Task Force members.