State Employees Health Plan Task Force
Buena Vista, Buck Library, New Castle, Delaware 19720
Thursday, November 5, 2015

The State Employees Health Plan Task Force Committee met on November 5, 2015, at the Buena Vista, Buck Library in New Castle, DE 19720. The following Committee members and guests were present:

Committee Members:
Ann Visalli, Director, OMB, Chairperson
Michael Begatto, AFSCME
JJ Johnson, Representative
Harvey Kenton, Representative
Geoff Klopp, COAD
Dave Lawson, Senate
Harris McDowell, Senate
Mike Morton, CGO
Evelyn Nestlerode, AOC
Bill Oberle, DSTA
Ken Simpler, OST
Jeff Taschner, DSEA
Karen Weldin Stewart, DOI

Guests:
Laura Beck, AOA
Colin Bonini, Senate
Tom Brackin, DSTA
David Craik, Pension Office
Ellen Dicuiru, DMMA
Hardy Drane, DOI
Jessica Eisenbrey, OMB
Andrew Kerber, DOJ
Brenda Lakeman, Director, OMB, SBO
Omar Masood, OST
Brian Maxwell, OMB

Guests *(cont'd)*:
Karen Peterson, Senate
Lisa Porter, OMB, SBO
Kimberly Reinagel-Nietubicz, CGO
Faith Rentz, Deputy Director, OMB, SBO
Paul Reynolds, DOI
Mike North, Aetna
Patti Friedman, Aon Hewitt Consulting
Mike Morfe, Aon Hewitt Consulting
Kris Hollstein, Chiropractor
Wayne Smith, DE Healthcare Assn.
Stacy Karp, ELAP
Steve Kelly, ELAP
Helen Demir, Express Scripts
Ben Twilley, Express Scripts
Sue Wolf, Express Scripts
Peg Eitl, Highmark
Jennifer Mossman, Highmark
Pamela Price, Highmark
Christine Schultz, Parkowski, Guerke & Swayze P.A.
Paula Roy, Roy Associates/DCSN
Roger Roy, Teledoc
Rebecca Byrd, The Byrd Group
Darcell Griffith, Univ of DE

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 22, 2015 Task Force meeting. Senator Harris made the motion and Controller General Morton seconded, the motion carried.

November 17 meeting overview and discussion
Ms. Lakeman presented a Timeline and Deliverables for the Task Force to conclude their work and meet the December 1, 2015 deadline to issue a final report to the Governor and Joint Finance Committee Co-Chairs. There were no questions or discussion related to the document. An additional public testimony meeting is scheduled for December 2, 2015 in the evening to present the final report and to allow members of the public to provide additional comments related to the work of the Task Force. A supplement to the final report will be issued summarizing the public testimony meeting. The State Employees Health Plan Task Plan Outlook mailbox will remain open for suggestions and ideas.

Vendor Presentations

Dr. Kris Hollstein is a Chiropractor who presented a handout with her own personal ideas for opportunities to save the State money that included long term goals, examples of the top five costly conditions, ideas to reward good behavior, embrace new technologies and shift to less expensive costs that provide more efficient treatment. There was discussion around Return-to-Work, supplemental insurance and more education and awareness in this area is needed for both the member and their primary care physician.

ELAP Services

Steve Kelly, President and Co-founder, gave an overview of the company whose mission is to provide healthcare cost management and employee advocacy services. Founded in 2003, ELAP's innovative approach is to bring rationality to the price of health services by working with clients to address the variability of cost for services by developing metric based pricing and reimbursements. Services include plan design assistance, direct contracting, provider claim audits, co-fiduciary, member advocacy and defense against unfair billing and collection practices and comprehensive analytics to measure performance, detect trends and identify opportunities. Examples of savings by another public sector client were provided. Director Visalli asked several questions about ELAP's experience working in an environment like Delaware and how ELAP would propose accessing the data necessary to determine the appropriate levels of reimbursement for services. Senator McDowell was interested in understanding how ELAP would interact with other innovative vendors and if their business model would identify areas of miscalculation or unnecessary services. Mr. Taschner requested other examples of variability of cost of services to help quantify examples provided. Mr. Oberle asked if ELAP thought the State had leverage with hospitals within Delaware as well as outside of Delaware and what, if any, impact would the State's success have on other employers and health plans in Delaware. Mr. Kelly provided responses to the Task Force members' questions emphasizing that utilizing such services would have a beneficial impact to the State and possibly other health plans in Delaware, particularly if the State started on a small scale while carefully considering the culture and benefit structure of the State plan. Treasurer Simpler stated that Mr. Kelly had successfully framed a solution; however, had not provided much to explain the source of the problem. Would utilizing such services move the State closer to Medicare and Medicaid reimbursement rates or close the disparity between Medicare, Medicaid and commercial reimbursement rates? In an environment where billed charges exist, there is no relationship to cost, higher cost equals higher reimbursement. There was much discussion about how to look at services and determine what is reasonable to pay for those services. Mr. Kelly provided the group with his opinion as to why the ELAP business model would not be effective in States that are regulated. Mr. Kelly expressed that the issue of what is a reasonable amount to pay for services is very complicated and he feels that quantifying costs is the most realistic and reasonable approach. Mr. Kelly will provide additional examples of how the ELAP model may be helpful to the State.

Express Scripts Program Review and Opportunities

Sue Wolf, Account Executive provided the Task Force with an overview of the discussion topics. Helen Demir, Manager of Financial Analysis, reviewed the FY2015 plan year commercial and EGWP (Employer Group Waiver Plan) financial performance providing total gross and member costs compared to the prior period. Combined, the commercial and EGWP plans experienced a 15.7% total cost increase over the prior period. Ms. Demir presented summaries of the commercial and EGWP plan costs by quarter for non specialty, compounds, specialty and Hepatitis C medications and Mr. Hammond, Senior Clinical Account Executive reviewed the top trend and cost drivers for both the commercial and EGWP populations. Director Visalli asked about the taxes paid by the plan and Ms. Demir explained that certain products are taxed in certain jurisdictions. Mr. Oberle asked if Express Scripts expected to see Hepatitis C costs to continue at the rate experienced in FY2015. Mr. Hammond explained that because there were new

Hepatitis C drugs that entered the marketplace in early CY2015, most plans experienced a significant increase in specialty spend as members previously diagnosed were utilizing the new medications. As the cure rate after successfully completing a course of treatment is extremely high, plans should not expect to see ongoing costs for members previously treated unless re-infected. Plans will continue to see costs for those who are newly diagnosed and this new treatment is prescribed. Senator McDowell asked about the spike in costs in FY2015 Quarter 1. Ms. Demir explained that it was common to see spikes due to seasonal illnesses and that it might be helpful to illustrate quarter by quarter expenses to the Task Force. Mr. Oberle wanted to understand if the changes quarter over quarter are a consequence of cost or utilization. Additional information will be provided to the Task Force. Treasurer Simpler asked why the plan cost per Rx was so high compared to other plans. Ms. Demir explained that much of the higher cost is driven by the State's plan design which allows a member to obtain a higher days' supply of medications for a lower cost. During the review of the EGWP plan costs, Mr. Taschner took note that the number of scripts was lower but costs per scripts higher than other clients. Ms. Demir explained that quantity (days' supply) and drug channels (type of drugs) play a major role in how these numbers look compared to other plans/clients as no two plans will have members with the same utilization. Ms. Demir also explained that the State's generic fill rate and mail order utilization is lower than other clients and those factors as well contribute to the higher per member costs. Mr. Oberle asked if Express Scripts could provide an estimate of savings the State would see if all drugs currently going through retail were obtaining them through mail order. Express Scripts will work to provide an estimate and noted that not all drugs can be obtained through mail order and will focus on those that could be moved to the mail order channel as part of their follow-up.

Ms. Wolf then presented several cost saving opportunities for consideration. The State's EGWP plan currently offers members the ability to obtain medications that are not standard to the Medicare Part D formulary. This is not uncommon as many plans made the choice when implemented EGWP plans to minimize disruption to their members by allowing them to continue to receive the same medications and plan design available to them as non EGWP plan members. This is not required; however, and specific to the State, there is opportunity for savings of $2.7M annually if the State chose not to cover medications that were not included in the standard Medicare Part D EGWP benefit. There are also medications being covered currently under the State EGWP plan that are also covered under Medicare Part B; however, the current plan design allows members to obtain these Part B medications through their EGWP plan. There is no coordination of benefits with Medicare Part B for the State to recover any of these costs. The State could realize annual savings of $1.2M if Part B drugs were not covered at all under the EGWP plan. If the State chose to implement a coordination of benefits arrangement where Express Scripts would coordinate with Medicare Part B on behalf of the State, an annual savings of $650,000 could be achieved. Ms. Wolf explained briefly the utilization management (UM) program that the State currently has in place to ensure that members are using the right medication at the most appropriate time through step therapy, prior utilization and drug quantity management programs. The State has an opportunity to realize additional savings by implementing a more aggressive UM program referred to as the Advanced Utilization Management program. An annual savings of $2.4M could be realized; however, approved 12,800 members would be impacted by expanding these programs to additional drug classes. Lastly, Ms. Wolfe introduced the Medical Channel Management (MCM) program to the Task Force members. This program covers specific specialty drug categories exclusively under the pharmacy benefit and seeks to address drug spend for these same medications through the medical benefit. Client savings average 8 to 12% which could mean as much as $7M annually for the State. Patient level savings examples were provided to illustrate how the program might work. It was suggested that for such a program to be fully effective in minimizing disruption to members and providers, implementation might be phased in starting first with oral and injectable medications before moving to intravenous immune globulin, growth hormone and

complex oncology medications. Treasurer Simpler asked if Express Scripts could provide any trend data similar to what has been provided by Aon. Express Scripts will provide the Task Force with their most recent annual drug trend report.

Contribution Methods, Plan Management and Retiree Options - Aon Hewitt Consulting

Mr. Morfe continued his presentation which he began at the October 22nd Task Force Meeting beginning with slide 19 – Options to Review – Premium/Cost-Sharing Structure which provided an overview of the options to be discussed related to cost sharing. Those options reviewed and discussed included: increase contribution percentages, implement salary-based contributions, subsidize dependents different than employees, eliminate "double state share" and implement surcharges. Mr. Begatto expressed concern that the group did not know total costs and therefore, it was difficult to talk about cost sharing. Mr. Taschner disagreed that the option to increase contribution percentages should be associated with cost savings and considered the option to be a cost shift from the State plan to employees. Mr. Morfe agreed that the options discussed in this portion of the presentation were essentially mechanisms that would shift costs from the plan to the employee as opposed to reducing or saving overall plan costs. With regards to the salary based contributions option, Treasurer Simpler inquired as to the impact on savings if employees migrated to lower cost plans. Mr. Morfe replied that savings would be impacted if significant plan migration occurred and that it was important to keep in mind that ultimately many of the options being discussed would need to be carefully considered and perhaps multiple options implemented simultaneously in order to bend the cost curve and ensure estimated savings would be achieved. For example, some form of plan design would be optimal in conjunction with a change in the premium structure to preserve savings. There was discussion related to the elimination of double state share to facilitate an understanding that the savings would actually be to the general fund as opposed to the health fund.

Patti Friedman reviewed options related to health plan management that included estimated values and timeframes for implementation. The State population's risk scores increased 20% between 2013 and 2014 and has a higher prevalence of chronic conditions compared to the state average. Many of these options are intended to increase member accountability and target areas of high cost. Implementation must include support tools and resources as well as clear communications to members to ensure the program and their intention are understood by members. Ms. Friedman highlighted a few successful and innovative programs that have been implemented by the State of Connecticut, the California Public Employees' Retirement System and the State of Kentucky. Value based designs target highest cost and risk chronic conditions and provide financial incentives and/or cost share reduction for services such as pharmacy and supplies, diagnostic testing and office visits. To qualify for the program, members typically have to participate in certain activities such as completion of a health risk assessment, biometric screening and/or work with a health coach. Referenced based pricing is a concept where a payment threshold based on median payments is established and provider reimbursement is capped at the threshold. Members are responsible for services incurred at locations or by providers who charge in excess of the threshold. Mr. Oberle was interested in understanding how to determine the actual cost in order to establish the threshold. Director Visalli replied that how you define reference prices would be important. Tiered networks for laboratory and high tech radiology services were also discussed. This option suggests implementing lower copays that would steer members to utilize lower cost facilities. In addition, for radiology selection of the facility could be part of the authorization process already required for these types of services. The Treasurer was interested in understanding the State spend for services such as lab, radiology and joint replacements compared to the State's total medical spend. Ms. Lakeman stated that implementing referenced based pricing for lab would be easier than radiology services.

Physical medicine management is an option that focuses on improving outcomes and efficacies of physical therapy and related physical medicine treatment by requiring an authorization process when eight or more visits are required or expected as part of the member's treatment plan. Commissioner Stewart asked about the number of visits allowed under the State's plans. Ms. Lakeman replied that it varied; however, medical necessity was required. The Treasurer wanted to know how the concepts could be quantified. Ms. Freidman replied that Aon Hewitt would continue to work on providing more information. Some employers have found that contracting directly with health care providers or third parties to provide onsite health services is effective in controlling costs, increasing access and improving member engagement. The University of Delaware offers a comprehensive patient centered medical home to its employees and dependents that includes a number of services such as physical and occupational therapy, mental health treatment, nutritional counseling and diabetes education. There is opportunity for the State to partner with the University to expand their program and services to all State members. Tobacco surcharges to incent employees to quit tobacco use and reward healthy behaviors through lower premiums is another option employers are implementing. The State has already implemented a number of tobacco free related initiatives and no copays on tobacco cessation medications. Director Visalli expressed concerns over enforcement. Senator Peterson, designee for Senator McDowell, felt that a focus should be made on all unhealthy behaviors and include obesity. Centers of Excellence for joint replacements and spine surgery that are based on improved quality and outcomes and offer members financial incentives to utilize was also presented. Mr. Oberle asked if the Bridge Health model was a possibility where members would go far away to receive high quality, lower cost services including travel and lodging reimbursement. The Centers of Excellence concept focuses on relatively local facilities for a small group of services. Lastly, rewarding wellness participation was reviewed as another surcharge option that could be imposed on employees who do not participate in certain activities.

Mr. Morfe then reviewed a number of retiree options for both non-Medicare and Medicare retirees. Projected expenditures for the retiree population and the actuarial value of their benefits was reviewed. An overview of the following options was presented: create two consumer directed health (CDH) plans with health saving account options for non-Medicare retirees with self-supporting premiums rates; utilize a non-Medicare retiree exchange allowing members to purchase individual-market products with a plan sponsor subsidy which would eliminate the excise tax for this population; utilize a Medicare retiree exchange that would also allow members to purchase individual-market products with a plan sponsor subsidy; replace the current Medicare supplement coverage with a national Medicare Advantage plan; and redesign the existing Medicare Supplement plan to a lower actuarial value. Mr. Oberle asked for clarification that the rates for the non-Medicare retirees to be self-supporting would be approximately 50% more than current. Mr. Morfe confirmed that the non-Medicare retiree rates produced a 160% loss ratio in FY15. Treasurer Simpler commented that the option was worthy of consideration due to the amount that the non-Medicare retirees are currently being subsidized. Senator Peterson asked why a Medicare equivalent plan could not be offered and require retirees to buy-up for anything of higher actuarial value. Director Visalli explained that it is not easy to take away benefits or reduce their value. Questions were asked about the retiree exchanges and what was moving employers to these types of options. Mr. Morfe explained that exchanges offer variety and choice for the member and allow the plan sponsor to allocate less funding. Some public employers are starting to move to exchanges to mitigate the potential excise tax. Mr. Oberle expressed morale concerns stating that exchanges are difficult for individuals to understand. Treasurer Simpler inquired about adverse tax consequences which Mr. Morfe said there were none. Director Visalli asked what produces the savings for the plan sponsor for Medicare Advantage plans if they allow for the same plan design with lower costs and Mr. Morfe explained that much of the savings is derived from better management and care coordination. Mr. Morfe concluded his presentation on retiree options by stating that redesign of the Medicare Supplement plan to a 90%

actuarial value would equalize this population with the active and non-Medicare population and the plans available to them currently.

Other Business

Ms. Lakeman shared with the Task Force that the draft Audit RFP titled Cost Recovery & Program Integrity is advertised for comment until November 13, 2015 and the goal is to release the final RFP no later than November 23, 2015. On November 9, 2015, the Task Force will receive via email the list of all the options discussed and will be asked to rate them as recommended, not recommended or neutral and return their comments so they can be aggregated and shared with the group for discussion at the November 17th meeting. Also, on November 17th the hospitals will speak.

The next Task Force meeting is scheduled for November 17, 2015 from 9:00 a.m. to 12:00 p.m. at Haslet Armory, Room 219 in Dover, DE. Representative Johnson made a motion to adjourn the meeting at 3:52 p.m.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office, OMB