State Employees Health Plan Task Force
Delaware State Fire School, Dover, Delaware 19904
Thursday, December 3, 2015

"These are the minutes taken of the final meeting of the State Health Plan Task Force held on December 3, 2015. These minutes were circulated to and reflect the comments of the members of the State Health Plan Task Force, but as no additional Task Force meetings are scheduled, the minutes cannot be approved by a vote of members at a meeting. If the Task Force meets again in the future, a vote to approve the minutes could be taken at that time."

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

Guests:
Laura Beck, AOA
Lisa Carmean, City of Milford
Dave Craik, Pensions
Hardy Drane, DOI
Jessica Eisenbrey, OMB

Guests *(cont'd)*:
Darcell Griffith, Univ of DE
Deb Hamilton, Cozen O'Connor
Chris Hudson, Univ of DE
Andrew Kerber, DOJ
Brenda Lakeman, Director, SBO
Omar Masood, OST
Brian Maxwell, Deputy Director, OMB
Lisa Porter, SBO
Pamela Price, Highmark
Faith Rentz, Deputy Director, SBO
Paula Roy, Roy Associates/DCSN
Christine Schultz, Parkowski, Guerke & Swayze P.A
Daniel Short, Representative
Wayne Smith, DE Healthcare Assn.

Patti Friedman, Aon Hewitt Consulting
Mike Morfe, Aon Hewitt Consulting

The State Employees Health Plan Task Force Committee met on December 3, 2015, at the Delaware State Fire School in Dover, DE 19901. The following Committee members and guests were present:

Introductions/Sign In
Director Visalli called the meeting to order at 9:05 a.m. and expressed appreciation to the Fire School for servicing the committee at this location. 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 November 17, 2015 Task Force meeting. Jeff Taschner made the motion and Representative Johnson seconded. Jeff Taschner initiated discussion on the motion carried to the November 17th minutes on page 4 referring to the hospital presentation and the statement "average weekly wages in Delaware are higher than Pennsylvania & West Virginia." Prefer the minutes to reflect if this pertains to hospital wages or entire labor market as there wasn't anything specific presented that the hospital's labor charges or costs were higher. Wayne Smith offered clarification that it is the American Hospital Association wages so it is hospital wages. Director Visalli suggested to approve the November 17th minutes contingent upon satisfactory resolution to the language on that particular issue and will ask Wayne Smith, DE Healthcare Association to send the data for review and it will be passed on to the committee. If all are comfortable, we will approve the minutes with that amendment. If it remains in dispute, it will be reflected in the minutes and amended later. With no objections, motion carried.

Director Visalli initiated meeting suggesting open dialogue to discuss comments from committee members on the draft report that was circulated. It was noted this process has yielded a lot of analytical and

educational findings with issues needing more study and dialog. SEBC may have to address some of the issues and further discussion needed.

Jeff Taschner, DSEA provided summarized comments of the first draft with factors that include:

1. Amount we pay for hospital services both inpatient and outpatient
2. The Express Scripts (ES) presentation showed our State's PMPM (per member per month) number of prescriptions is the lowest compared to other groups
    a. however the cost we pay for the prescription is higher
    b. when asked if it could be the 90 day prescription plan, no clear definitive answer from ES
    c. Question remains if we are getting the best deal possible for drug prices
3. Truven provided the third factor which was our high-cost claims
    a. an increase from $498K to $607K with an increase in costs around $198K up to $205K, being driven by hospital and drug for the first two factors
4. Delaware Center for Health Innovation, Aetna, Highmark and ELAP Services all indicated the Fee-for-Service model is broken. We need to determine the cost to pay for these services before considering any other change.

5. Our (DSEA) recommendations are to really look at Metric Based Pricing (MBP).

6. The Diagnosis Related Grouping (DRG)
    a. is a concern as Highmark targets to move 80% by 2016 or 2017
    b. more information is needed about DRG
    c. if the goal is to slow growth from what we already have, and what we have is too high, not sure if DRG is the answer

7. The Centers of Excellence (COE)
    a. this concept is referenced throughout the report, yet we need more in-depth detail
    b. it would be valuable to have this group return for further discussion
    c. follow-up received by COE is that western states utilizing this concept are seeing 20-40% savings

8. Further thoughts:
    a. need to reduce costs
    b. we need to be sure we are getting the best deal possible before we consider any other changes
    c. the process of this Task Force has allowed us to discover questions that we didn't know upon the start of this committee but unable to obtain answers and this needs to be continued
    d. this will help save money for the State, for the people we represent, it means the benefits will be there when needed and helps the citizens of Delaware
    e. DSEA is interested and willing to continued participation to help reach solutions to drive down costs

Treasurer Simpler complimented Mr. Taschner and DSEA for their thorough summary and reiterated the difference between Findings and Recommendations along with comments on the draft report:

1. Agree on what was put forward with the pharmaceutical costs
    a. our per member cost for actives seem to be in line with our peer groups
    b. data shows we are significantly higher; issue of costs versus use
    c. the retiree side shows a conceivable higher use as well as higher cost
2. Agree with medical claims for active employees with Truven data
    a. activity that increased our medical spend is the high cost claimants
    b. the number of claimants is not a cost issue, it's a use issue
    c. length of stay in the hospital went from 4.1 to 4.6 days

d. a large part of the driver with hospital amounts could be deemed as "use" versus pure price
e. this data needs to be examined more aggressively to determine where costs are coming from
f. Highmark and Aetna's data for Delaware hospitals compared with West Virginia and Pennsylvania are startling facts
g. the hospitals stated they agree but also disagree since the sample set that Highmark and Aetna used includes different types of hospitals than available in Delaware
h. we did not explore the quality of outcomes the different hospitals produce which is a huge piece
i. need continued examination of the hospital data and making it the focal point of our study is important but also treacherous if we don't get the correct comparisons
j. need to examine the spend with our hospital costs as we have three hospitals that account for two-thirds of our spend

3. Metric Based Pricing
    a. hospital spend is $300M and we have a $100M problem for just next year; even if gross over billing is discovered, there's not enough money there to solve the current problem
    b. we have to be realistic about what numbers this will produce even if we go there
    c. how do we get to MBP in a short period of time
    d. this will be a challenge with legislature
    e. another challenge with MBP is an entirely new pricing mechanism for our hospital system
    f. we are responsible for 122,000 lives with our healthcare that accounts to less than 15% of Delaware's population; to reinvent a care system that handles 950,000 people, we need to be very cautious if we go down this path
    g. MBP is a great concept but am cautious about going to an entirely new payment system with the amount of time it's going to take and for the amount of savings it will generate

4. The Treasurer commented with one finding that he believes everyone will agree with is that we are all startled by the cost curve. With the ten years of data supplied, this finding shows:
    a. our health costs are growing 6% per year
    b. the trend for healthcare is up to 7% for both medical and prescription
    c. our revenue is only growing 3%

5. Change is happening and we need to think of how to accelerate that change:
    a. a movement from sickness to wellness, from chronic/acute care to preventive care
    b. there is great opportunity to accelerate these types of changes
    c. it is frustrating these changes are not happening fast enough

6. More difficult to find agreement on if our population is sicker:
    a. data shows that Delaware is sicker than our regional peers and the nation
    b. this has tremendous implications and not surprising that if we're sicker, then more care is consumed
    c. hospitals presented the CMS pie chart showing Delaware 25% higher than the national average
    d. the Mid-Atlantic region and other states are 10 to 15% higher, but Delaware is higher
    e. we have all of these prevalence factors and we are sicker in the chronic conditions which drives our healthcare costs higher
    f. this is a piece of data to be wrestled with; it has implications about use as opposed to price
    g. and why we are consuming more healthcare
    h. this is an area to explore based on what is in the data set

7. Employee Compensation
    a. the most controversial and most difficult conversation
    b. the initial data that has been presented only addresses the health benefits piece, we haven't talked about employee total compensation, pension benefits, or other fringe benefits
    c. the health benefits data indicates our State contribution percentages are higher than most
    d. data shows 86 to 87% is the more than normal average and we are at 91.6% on average
    e. this is a lot of money and if true and relative to our regional peers, how do we have a dialogue on this
    f. our wages are down
    a. our pension costs down
    b. this is a fair conversation to have
    c. if our employees have elected to take more of their compensation in health benefits, then that should be high
    d. this data has not been seen

There is basis to agree with DSEA on some of their recommendations that they put forward but the Treasurer prefers to be cautious on others. Would like to get to where these other findings drive us.

Director Visalli made some follow-up comments with the first point on the newspaper article about the trend nationally in healthcare costs which focused a lot on prescription drugs, increased aggregate spend this current year and last year were the highest since 2009.

The second point is findings we have with our population show that our health management has not been successful. There are high incidents with the muscular skeletal issues driven by weight, high prevalence of diabetes, and possibly driven by geographical locations as raised by Representative Johnson.

Third point is the short term, long term and what we face in terms of the FY17 health fund budget. Some of the ideas mentioned are going to have long term impact but will also be more challenging; similar to the chart shown by Aon with long term big savings but also more difficult to implement or establish. We need to continue but in the short term, with no reserve and dipping into the claims liability, we continue to closely monitor our claims experience this year, continue to work with the hospitals and third party administrators to make sure we're not underestimating or overestimating the problem. Dialogue followed around the reserves used, healthcare trends and bending the cost curve.

Treasurer Simpler shared that the 10 year data showed an overall average 6% growth, the standard deviation within that 10 year period is about 3.5%. If starting with a growth rate of 6%, this leaves about 2.5% on each end to capture roughly two-thirds of the expected outcomes. In one year there were zero claims and a few year's claims grew 10%. To have a 95% confidence to capture all that, you'd have to prepared for as little as negative 2% growth to as high as 14% growth in the health fund. That is where the reserve comes into play as the trend data shows 7% growth. If we keep at 6%, and only if a reserve exists, that would mitigate those outside years.

Director Visalli reminded the committee that for three years, we were trending at 3% and the country was between 5 to 6%. We did not increase premiums when we had a surplus available.

Representative Johnson provided comments:
1. Hoping to find a simple solution
2. A lot has been learned during this process

3. There are still a lot of issues and only comfortable to report back to the General Assembly and the administration of our findings below versus recommendations
    a. how significant Hepatitis C is affecting the cost of health care
    b. the fact the citizens of Delaware are less healthier than the rest of the nation
    c. maybe we are not on the right model of being self-insured as Senator McDowell states

Director Visalli explained the actions taken during last year with the deficit and how the Task Force Committee was formed. She also noted that premium structure is the strongest item currently in the toolbox and acknowledged this will not solve the entire problem. Findings and any recommendations will be drafted and circulated for review.

Evelyn Nestlerode shared comments from the Chief Justice:

1. Supports searching for a "major league" advisor right away
    a. meaning we should look at the most effective corporations and universities in the United States, to see who they hire to consult and help them make these kinds of decisions
    b. believes we need improved guidance from a consultant, whether that be the current consultant or a new one

2. The Chief Justice has been updated on previous meetings by Ms. Nestlerode
    a. The Chief Justice has read the materials from the committee, including the draft report
    b. not comfortable supporting or eliminating ideas at this point, or agreeing to the draft as written

3. One primary concern is no clear definition of the current problem or how we got here
    a. this has likely been a structural issue for some time based on financial statements
    b. used the example from the report of generic drug use (79% vs 81%) as this is not what got us into this problem

4. Concerned over our use of the consultant
    a. we were provided with just a list of every possible idea without analysis, guidance or context
    b. we were asked to vote on it but we are not healthcare experts with experience in implementing these ideas
    c. we asked for guidance at the last meeting by asking for AON's top recommendations (least pain, most bang for the buck, most successful in implementation), but were not provided with recommendations
    d. also when we have been given conflicting information from the insurance companies and the hospitals, we didn't get any guidance from AON

5. Would like to see the report look at overall employee compensation as a backdrop to compare with other states in the region, not just the insurance part of our compensation. Also trends of overall compensation.

6. The Judicial Branch fully supports the elimination of double state share.

7. Concern over recommendations includes:
    a. any recommendation that would put up barriers to health care
    b. any recommendation would put undue burdens on employees by making individuals do too much personal research prior to seeking medical care
    c. any recommendation which would include a costly solution that doesn't take employee salary into account

Mr. Oberle shared our contributions levels are less than the regional peers and he struggles over who those regional peers are as Aon conveyed this information was proprietary in nature.

- Treasurer Simpler interjected that Aon gave us 46 members of the public but not regional peers and would like to have this data.
- Mr. Taschner commented this data may have represented 102 different benefit plans, but we do not know the types of benefit plans and whether comparable to our Basic, CDH, PPO, HMO, etc.

Mr. Oberle spoke on his own behalf providing comments:

1. This problem is severe
2. There are many analogies with the cost drivers between the Workers Compensation committee and what is occurring here today. That committee allowed the members over six months to gather facts
3. There's a shorter term solution that may be a hybrid from conversation with ELAP and take some of the high cost procedures, the drivers, on the cost side of the equation and use it as a model to apply Metric Base Pricing (MBP) to some of those procedures for a period of a year to gather data and establish exactly where the cost savings can be had
    a. Not suggesting to move totally into the MBP direction the first year but do believe there is merit considering a partial move to MBP on some of the procedures
    b. implement at least partially a MBP system this coming year
4. Delaware was mentioned as being the unhealthiest state in the nation yet data just released last week stated Dover was one of the top ten healthiest cities in the country
    a. Not sure what measures are being used to establish these conclusions; need factual data

Treasurer Simpler stated hospitals are experimenting with bundled care and episodic care which takes time to figure out and assemble all the pieces to offer the lower price point. It moves very slowly as Highmark and Aetna explained and is frustrating. If they do assemble the pieces, they know they can deliver at that value price. My distinction and concern is that MBP starts at a different point and that services subject to MBP will be possibly be shifted into other areas of care not in MBP. The Treasurer emphasized, to Representative Johnson's point, change is coming to the way we pay for care, on the provider's side and the payor's side which hasn't been discussed today. Comments included:

- We do control the way we consume care; focus more on consumption of care
- Senator McDowell talked about that our current plans don't incent behavior change and consumerism
- We could shift our plans to plans that have consumption behavior penalties
- Or shift to plans that are no more costly but encourage the appropriate consumption behaviors
- We could build CDH plans that are vertically and equitably fair to benefit those at the lower end with little cost to the higher end with more cost
- We have to force the hospitals away from fee-for-service to some form of different pricing whether MBP, bundle, DRG's - - we need a different payment mechanism for the hospital side

These are goals of this Task Force to incent and further accelerate the change from the provider side and how they bill and also change the way we pay. The payment and consumption part is where we need to focus on to move in the right direction.

Mr. Taschner reiterated that we need to deal with this issue short term but not take attention off the long term as:

- The third party administrators were honest with us stating they need more help and used the term leverage
- Maybe it is time to present the MBP or other things
- The CDH plan may benefit people but members don't understand the change from a PPO/HMO would mean; this change would save employees more money and doesn't save the State a lot of money

- A Chiropractor group came in and stated they could save money with the spinal issues and avoidance of opiate dependence. This was not captured in the report along with information from other groups

Director Visalli mentioned that in terms of the speakers, plans are to include all the materials. To elevate the findings to the main body is a good suggestion. Dialogue continued around the different models for payment (MBP, DRG) and the example of the workers compensation committee.

Treasurer Simpler stated we don't want this issue at the table every year or to pass more costs to employees so the 6% growth has to come down to 4% in the curve, slowing the growth rate so our revenues can support it. The Treasurer does concur to get the appropriate people at the table with the hospitals, and our providers to continue to address this problem. He is not opposed to MBP, just worried about the capacity to implement it in a timely way that doesn't prove to immensely cause disruption.

Ms. Lakeman spoke that Matt Swanson from the Delaware Center for Health Innovation (DCHI) did not have enough time to provide the scope of their work over the past two years. DCHI has had the payors, providers and the hospitals at the table talking about payment reform and patient engagement. This process has been moving along and progressing.

Other suggestions brought forth were:

1. Short term and long term solutions with an on-going process is needed
2. Relook at State Employees Benefit Advisory Committee (SEBAC)
    a. Implement with a different body of people to drill down into the details to advise SEBC
3. Drive people from one plan into another plan
    a. Members need education to understand savings
    b. HMO and PPO are very similar; is PPO or both still needed
4. Bring in a Health Savings Account (HSA)
    a. HSA would benefit employees more than the Health Reimbursement Account (HRA)
    b. Dialogue already in process with Highmark and Aetna
5. To implement plans for new employees only, it is easy but can create problems with two tiers
6. Rate setting process

Wayne Smith from Delaware Healthcare Association (DHA), shared that the workers compensation billings for any hospital in Delaware do not exceed 1.5% of their total revenues (larger hospitals); most hospitals are under 1%. This was cost shifting. Hospitals have to make their 3% which is the industry average. Workers compensation is a very tiny piece of the hospitals and physician's business looking at the aggregate. DHA committed three years ago to the Governor and federal government and has a $35M grant from CMS for this State Innovation model that encompasses change for the long term. This includes rate changing scenarios that has been discussed such as moving away from Fee-for-Service to other payment methods like bundled payments. It would be disruptive to go with a different rate mechanism that is going in a different direction.

Additional Comments / Remarks:

1. The Treasurer inquired that as the hospitals are all non-profit hospitals, is it possible to see if these hospitals are getting unduly rich; where is the money going which may satisfy part of this inquiry?
    a. Director Visalli remarked the Center for Health Innovation is already working with the hospitals on this effort, more jointly, and this information is most likely being shared already; we will start there.
2. The Treasurer asked if it is possible to come up with one plan that is the best in class that starts with a premise of being neutral to people's pocketbooks.
3. It was noted Mike Morfe, Aon will facilitate the findings and get a framework started.
4. Geoff Klopp commented last year we had a $60M problem, the State employees provided $15M. The hole we are attempting to fill now is around $100M, which is the immediate issue to be resolved. The question is where does that money come from: the legislature, budget, State employees?
5. Senator Lawson mentioned the perception and creditability with employees and the public.
6. Senator Lawson stated education is critical; have one plan (versus our current seven plans); if member wants more in a plan, than the member pays for it.
7. Representative Johnson stated our rates are not set in a vacuum. The fact we don't have a charity hospital in Delaware affects the rate. There are other things we could do with the legislature to address the issues that could probably bring down our rates and we should be looking at this factor.
8. Mike Begatto brought up the issue of State employees having to visit their doctors when out sick to satisfy their management for sick leave.
9. The Treasurer suggested that in reference to Senator Lawson's credibility comment to put together a two to three page summary to be easily read by all with suggested findings:
    a. Growth rates
    b. Delivery system changes that are going on
    c. Sickness of our population (incomplete with still more data needed)
    d. How our employees are treated fairly over time – from a total compensation perspective to a healthcare perspective
    e. Are our care networks getting unduly rich
    f. Study group to commit to solve this problem for the long term; need vested legislators
10. Mr. Oberle spoke of the reserve account for Christiana Care of over $1B. We should be able to look at these numbers. A press article last week of a teaching hospital (Univ of Utah) reduced their costs by 30% with better outcomes by going back and looking at every aspect of their healthcare delivery system within that operation.
11. The Treasurer reminded that Express Scripts presented savings to the kind of changes we're looking for that doesn't hurt our employees but might create processes members may have to go through.
    a. Director Visalli stated this could be brought before SEBC to pursue
12. The Treasurer also suggested regulating and setting rates is another concept but would like to hear what the current care providers would say regarding disruption and if worth exploring.

Mike Morfe of Aon was asked to drive the committee to conclusion and comments were:

1. Findings versus Recommendations
2. Recommendations on how to go forward
    a. Continue with a "deep dive committee"
3. Legislators need to be involved
4. There is a very real short term versus long term issue here

Other Business

Ms. Lakeman shared there was a Public Testimony meeting held December 2, 2015. The Insurance Commissioner attended, approximately 20 others and a few did speak. Some people spoke of being leery of

the Exchange, keep the benefits where they are, some mentioned the chiropractic services, and some comments on last year's change in removing the erectile dysfunction drugs. Another Public Testimony meeting is scheduled on January 4th at DelTech Terry Campus on the post-report for people to comment. Since the report will be on Findings, not Recommendations, we expect less concern. Another meeting will be scheduled in early January in New Castle County.

Closing Remarks

Mr. Oberle requested that both Highmark and Aetna's testimony of their belief the State is being over-charged be included in the Findings as noted in their presentations. Director Visalli added that all the presentations and minutes will be included and to contact her if anything is not captured or clear in the Executive Summary.

The Treasurer summarized a critical part of this exercise as these would significantly change the way we think of this problem:

1. Are our hospitals getting fairly or unfairly compensated?
2. Are our employee benefits overly rich?
3. Is our population sicker than other states in the nation?

Mr. Oberle asked if there will be a core group moving forward to more deeply examine these findings. Treasurer Simpler concurred with this idea. More examination is needed to be noted as a finding with a core group to lead the examination to be stated as a recommendation.

Commissioner Stewart added the Healthcare Commission is doing a lot of the same work in this area.

A motion was requested to adjourn the meeting. Senator Lawson made the motion and Mr. Klopp seconded the motion. Meeting adjourned at 11:52am.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office, OMB