MINUTES FROM THE JOINT MEETING OF THE FINANCIAL AND HEALTH POLICY & PLANNING SUBCOMMITTEES TO THE STATE EMPLOYEE BENEFITS COMMITTEE
JANUARY 24, 2019

The Joint Meeting of the Financial and Health Policy & Planning ("HP&P") Subcommittees to the State Employee Benefits Committee (the "Committee") was held on January 24, 2019 in the Large conference room of the Statewide Benefits Office ("SBO"), 97 Commerce Way, Dover, Delaware 19904.

Committee Members Represented or in Attendance:

Health Policy & Planning Subcommittee

Director Faith Rentz, SBO, Department of Human Resources ("DHR") (Appointee of DHR Secretary Johnson), Chair
Ms. Judi Schock, Deputy Principal Assistant, Office of Management & Budget ("OMB") (Appointee OMB Director Jackson)
Ms. Susan Steward, Policy Analyst, Office of the State Treasurer (Attending on Behalf of Treasurer Davis)
Mr. Stuart Snyder, Chief of Staff, Department of Insurance ("DOI") (Appointee of Commissioner Navarro)
Mr. William Oberle, Delaware State Trooper's Association (Appointee of the DSEA, Jeff Taschner)
Secretary Kara Walker, Department of Health and Social Services ("DHSS")

Financial Subcommittee

Director Faith Rentz, SBO, DHR (Appointee of DHR Secretary Johnson), Chair
Ms. Emily Thomas, Fiscal & Policy Analyst, OMB (Appointee of OMB Director Jackson)
Ms. Susan Steward, Policy Analyst, OST (Attending on Behalf of Treasurer Davis)
Mr. Stuart Snyder, DOI (Appointee of Commissioner Navarro)
Mr. Steven Costantino, DHSS (Appointee of DHSS Secretary Walker)
Ms. Judy Anderson, Delaware State Education Association (Appointee of the DSEA, Jeff Taschner)

Committee Members Not Represented or in Attendance:

Health Policy and Planning Subcommittee

Mr. Tanner Polce, Policy Director, Office of the Lt. Governor (Appointee of Lt. Governor Hall-Long)
Ms. Victoria Brennan, Sr. Legislative Analyst, Office of the Controller General ("OCG") (Appointee for CG Morton)

Financial Subcommittee

Mr. Keith Warren, Lt. Governor Chief of Staff (Appointee of Lt. Governor Hall-Long)
Ms. Ruth Ann Jones, Legislative Analyst, OCG (Appointee for CG Morton)

Others in Attendance:

Deputy Director Leighann Hinkle, SBO, DHR
Mr. Kevin Fyock, Willis Towers Watson ("WTW")
Mr. Chris Giovannello, WTW
Ms. Jaclyn Iglesias, WTW
Dr. Ge Bai, Johns Hopkins Carey Business School
Dr. Aditi Sen, Johns Hopkins Bloomberg School of Public Health
Ms. Cherie Dodge Biron, Controller, DHR
Ms. Christina Bryan, Delaware Healthcare Association
Ms. Rebecca Byrd, The Byrd Group
Ms. Nina Figueroa, Policy Advisor, SBO, DHR
Ms. Katherine Impellizzeri, Aetna
Mr. Chris Manning, Nemours
Ms. Mary Kate McLaughlin, Drinker Biddle
Ms. Jennifer Mossman, Highmark Delaware
Ms. Paula Roy, Roy Associates
Mr. Aaron Schrader, Human Resource Manager, SBO, DHR
Ms. Martha Sturtevant, Executive Assistant, SBO, DHR
Ms. Elizabeth Lewis Zubaca, Hamilton Goodman Partners

CALLED TO ORDER

Dir. Rentz called the meeting to order at 2:03 p.m.

APPROVAL OF MINUTES – DIRECTOR RENTZ

Financial Subcommittee

A MOTION was made by Mr. Costantino and seconded by Ms. Thompson to approve the minutes with noted typos from December 18, 2018 Financial Subcommittee meeting.
MOTION ADOPTED UNANIMOUSLY.

Health Policy & Planning Subcommittee

A MOTION was made by Mr. Oberle and seconded by Ms. Schock to approve the minutes with noted typos from December 18, 2018 Health Policy & Planning Subcommittee meeting.
MOTION ADOPTED UNANIMOUSLY.

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ

State Employee Benefits Committee Update

The Committee did not take action on recommendations of the Subcommittees, but action on Plan Design is expected on February 11. The Committee discussed SB 139 and requested further evaluation be delegated to the HP&P Subcommittee.

Mr. Oberle noted that he would not be able to attend the next meeting, and asked about a possible designee. Dir. Rentz responded that the resolution that formed the Subcommittees requires that each Committee member designate a Subcommittee member, but it does not allow for the Subcommittee member to send an alternate, adding that someone attending on behalf of an appointee is free to attend and listen to the discussion, but not participate. Mr. Oberle requested that Dir. Rentz encourage the Committee to attend the Subcommittee meetings.

Mr. Costantino queried whether policy under consideration by the HP&P Subcommittee, that may have a financial impact, should engage the participation of the Financial Subcommittee. Dir. Rentz responded with the example of SB 139, stating that the HP&P will work on Plan Design, but would benefit from input from the Financial Subcommittee. She further added that the Financial Subcommittee may benefit from crossover with the HP&P Subcommittee as needed.

HEALTHCARE COST LANDSCAPE ANALYSIS & DISCUSSION – DR. ADITI SEN & DR. GE BAI, JOHNS HOPKINS

Impatient Prices and Hospital Profitability in Delaware

The research presented by Dr. Aditi Sen and Dr. Ge Bai is funded by a grant from the Arnold Foundation to compare variations between private sector and Medicare prices and practices in order to support state level efforts to lower healthcare prices. Data was collected from MarketScan, which captures 130,000, or 36%, of 18-64 year old individuals who live in Delaware, and that have employee-sponsored plans from 2012-2016. MarketScan data is collected from 350 issuers and captures utilization, expenditures and enrollment across active employees, early retirees, COBRA enrollees and dependents. The data cannot look at specific hospitals, providers or insurers, and stated that the analysis focused on an average inpatient market sample of 6,700 individuals (2012-2016), and a Medicare market sample of 5,900 individuals (2016) across the three Metropolitan Statistical Areas ("MSAs") that cover Delaware (Wilmington, Dover, and Salisbury).

Private prices for select impatient services were compared across MSAs and were noted to be similar: impatient stay, hip replacement, knee replacement, cesarean section, vaginal delivery and percutaneous transluminal coronary angioplasty. On average the private sector prices are two to three times that of Medicare prices for the same impatient services. Mr. Oberle queried if Medicare is reimbursing too little, or if the private sector is priced too high. Dr. Sen responded that after reviewing the data, it is her determination that private prices are too high. Mr. Costantino asked if there was a difference in how Medicare pays versus how the private sector pays. Dr. Sen responded that while the formula for Medicare pricing is known, private sector negotiations, and market factors make it difficult to make an equal comparison on how prices are set.

Dr. Bai challenged the cost-shifting argument, that hospitals must increase their prices to offset what they lose in fixed Medicare pricing, and instead hospital costs are flexible, not fixed. She cited the Medicare Prospective Payment Advisory Commission ("MedPAC") Report (2018), which stated that hospitals respond to lower prices by lowering their prices. She stated that without high pressure to lower costs, hospitals will continue to increase costs.

Delaware Hospital profit margins in the Wilmington and Salisbury regions by hospital were presented, which ranged from -5% to 17%. The national median profit margin in 2016 was 4%, and Maryland ("MD") and Pennsylvania ("PA") were at 6%, and 5% respectively. Mr. Fyock asked if the analysis looked at profit margin by year. Dr. Bai responded that to date they have not looked at previous years. Ms. Anderson asked if donations to the hospitals were included in the profit margins. Dr. Bai responded that they were, and added that it also included government appropriations.

Mr. Oberle stated that hospitals can still make money if reimbursed at the Medicare rate. Dr. Bai responded that on average if a hospital is reimbursed by Medicare at $100, the hospital's cost is $101. Mr. Oberle stated that he wasn't

certain if Medicare rates should be the benchmark for Referenced-Based Pricing ("RBP"), and that hospital administrators have argued that they would go bankrupt if they were only reimbursed at Medicare rates. Dr. Bai restated her position that pricing is a response, and that if rates decreased hospitals would be more conservative.

Mr. Costantino noted that in his experience, he has not seen the commercial market drop as a result of Medicare payment increases. He queried whether non-patient revenues have been backed out of the analysis. Dr. Bai responded that they had not, noting that a large appropriation, from one-third to one-half, comes from government subsidies (e.g. servicing rural or low-income patients), and those subsidies are still related to patient care. Dr. Bai added that they compared the annual reports of Delaware hospitals with the Centers for Medicare & Medicaid Services ("CMS") cost reports. The overall income could be reconciled, but when they only looked at patient care, there was a large discrepancy, and therefore lost confidence in the data.

Mr. Fyock asked if the CMS cost reports, or the Johns Hopkins analysis, had normalized data across hospital systems, noting the variation in profit margins that would result from the standard services provided across all hospitals: emergency room, maternity, and basic imaging versus high-cost imaging, and specialized orthopedic services. Dr. Bai responded that CMS does not, but added that the cost to the provider would be offset by the higher revenue for the procedure.

Ms. Iglesias asked if there had been any severity adjustment to the data. Dr. Bai responded that the profit margin data had not been risk adjusted, but that the labor price could be adjusted as well as the Case Mix Index could be adjusted to account for the complexity of patient treatment by hospital.

Mr. Oberle asked if same assumptions were used for MD & PA. Dr. Sen responded that they are calculated with the same assumptions, but added that risk adjustments had not yet been done.

Ms. Anderson asked if the data was reviewed further back than 2012. Dr. Sen replied that the data did not permit for a longer analysis.

Policy Considerations for State of Delaware Group Health Program

Policy considerations for the State Group Health Insurance Plan ("GHIP") that fall within the authority of the Committee were presented. The first consideration is to close the gap between Medicare and state employee healthcare over time. Dr. Bai provided the example that 200% of Medicare in year one, followed by subsequently reducing payments by 20% each year until reaching 100% in year six. Other options include capping amounts for certain procedures.

Mr. Snyder asked if the comparison data reflected only non-profit hospitals. Dr. Sen responded that there are for-profit hospitals included in the data for PA and MD. Ms. Anderson inquired about the differences in profit margins between for-profit and non-profit hospitals. Dr. Bai responded that the data was not separated, but it could be. Mr. Snyder stated that because all of Delaware is non-profit, and the data presented reflected that Delaware's expenses were comparatively higher, that he would like to see the breakout for comparison.

Ms. Steward asked if there were any price parity introduced between the different MSAs, adding the example that there are different cost of living adjustments between Philadelphia and Sussex County. Dr. Sen responded that the current analysis did not account for cost of living, but it is something that could be included. Ms. Steward added that the information would be helpful in negotiations. Dr. Bai noted that they could adjust for the labor market and the Case Mix Index, and added that input prices on the wages could also be added. Mr. Costantino noted that Medicare payments are adjusted by region.

Mr. Fyock queried if the research reflected whether other states were more likely to utilize legislative or program adjustments. Dr. Sen responded that there was a mix of both, but more detailed information could be made available. Mr. Oberle noted that balanced billing would require legislative action. Dr. Sen added that an additional consideration within the authority of the Committee would be to review existing Third Party Administrator ("TPA") contracts for potential negotiations.

Policy considerations requiring legislative action were presented. Connecticut has regulated facility fees outside of hospitals, removing the additional facility fee and therefore the incentive for hospitals to buy up physician practices.

Other states have legislated removing regulatory barriers (e.g. Certificate of Need), and initiated broader payment reform (e.g. all-payer rate setting). She queried the Subcommittees for their recommendations.

Ms. Steward queried whether the analysis considered the availability of commercially zoned areas in Delaware for medical facilities. Dr. Sen responded that zoning was not included in the current analysis.

Mr. Costantino inquired about the outcomes of having a Certificate of Need requirement. Dr. Sen responded that there is no evidence that the requirement resulted in contained costs or improved outcomes, but added that there is limited research on removing the requirement.

Ms. Anderson asked if they could back out hospital fundraising for comparison. Dr. Bai argued that after comparing annual reports, she believed it would be difficult. Dr. Sen added that if too much is cut, neither would be perfect.

HEALTHCARE COST CONTAINMENT STRATEGIES – MS. JACLYN IGLESIAS, MR. KEVIN FYOCK, WTW

Revisiting the GHIP Strategic Framework

There was a brief review of the multi-year Strategic Framework approved by the Committee in late 2016, followed by an overview of health care delivery solutions. Several options have been implemented or are in the process of implementing, as part of the Strategic Framework, and it was noted that site of care steerage and RBP are more difficult options to implement.

Mr. Fyock stated that RBP was less about modifying a global reimbursement model, but rather a reference for specific procedures and educating members on the allowance for those procedures. Mr. Oberle asked how specific procedure pricing versus global RBP would be implemented. Mr. Fyock responded that Aetna and Highmark have existing procedures in place, additionally further examination would be done on implementation by other states.

Significant modifications to the GHIP will be influenced by the provider community, legislative and policy arms, and Healthcare Benefits. The cost of healthcare in Delaware can be influenced by the Committee, and the Provider/Payer community. There is an opportunity to work together with TPA partners to move initiative forward.

Mr. Costantino queried how the State can move forward with the Accountable Care Organizations ("ACOs") initiative and limit disruption to members. Mr. Fyock responded that there is a point of care opportunity to work with the State's existing TPA partners and their existing ACOs, but that the best opportunity may be to incentivize at the point of enrollment, where people are incentivized to go to providers through a lower deductible or higher insurance model.

Referenced-Based Pricing

Mr. Fyock asked the Subcommittees to think about ways to take costs out of the system, rather than cost shifting. The goal being to reduce costs without making any one entity bare a greater share: the same proportion of costs to members and the State remains the same. Reference-based pricing is defined as a fixed amount plan sponsors pay or "reference" price toward the cost of a specific health care service, instead of a discounted rate off the billed provider charge. Members must pay the difference in price if they select a more costly provider or service.

Mr. Oberle queried whether RBP applied only to a subset of procedures could result in a cost shift internally where the cost limitation would be recaptured. Mr. Fyock responded that it was a possibility.

Ms. Iglesias stated that RBP works best with coinsurance-based plan designs, and is limited to a small set of elective procedures. As a result, it equates to a small subset of the total cost of a plan, and therefore cost savings is limited. Prices are usually set using a multiple of Medicare pricing (e.g. 150%) with influence by free market negotiations. Contracts can be arranged by TPAs who arrange for access to the providers who have agreed to accept RBP, which may be more limited than in a PPO network. Balance billing is likely, and difficult to avoid depending on the scope of the network, if a patient obtains care outside of the designated providers. Successful implementation must be in conjunction with intensive member education and communication campaign, without which the plan has potential for member pushback. Mr. Fyock stated that when initially presented to the Committee, it was discussed that while great in theory, there is a high risk of disadvantaging membership (balance billing), and the dollars can be significant.

Mr. Oberle said he would not advocate for RBP without protecting against balance billing and queried how best to determine the right reimbursement.

Dr. Walker expressed her concern about the unintended impact to members. She queried if any of the RBP plans compared had similarities to Delaware. Ms. Iglesias responded that the data is limited as RBP is not commonly adopted, adding that of those compared, some had already been discontinued.

The reference price is set at a specific percentile based on what is reasonable and customary for a particular location with input from the plan sponsor and vendor partner. Aetna and Highmark have the ability to implement RBP, but differ in covered procedures and provider network. Some contracts allow providers to balance-bill up to the contracted allowance, while others do not. If balance-billed, it may or may not count toward the member's annual out-of-pocket maximum. Aetna and Highmark responded that they are unable to determine if RBP results in meaningful behavior change or financial outcomes, as the sample size of members and participating providers is too small.

Referring to the response from Aetna and Highmark, Mr. Oberle requested the pricing for the existing RBP plans, adding that the price could influence the outcome. Ms. Iglesias said the information can be requested.

Examples illustrating the potential impact to members with a co-pay based plan versus a RBP were provided. Examples illustrating the potential impact to members with a coinsurance-based plan versus a RBP were provided. Mr. Oberle expressed that the examples provided were the worst case scenarios, adding that he did not want the examples to deter a rational conversation. Mr. Fyock responded that the member payment should be largely irrelevant, because it should be implemented with something in place that prohibits balance billing, and the member should know exactly what their costs are upfront.

The Affordable Care Act sets limits for cost-sharing, and the threshold could be violated by the additional costs that the member may pay out-of-pocket. Employers offering reference-based plans should ensure adequate and timely access to providers accepting the reference-based price, and certain services (e.g. Emergency) must be excluded as to not deter needed care. Additionally, an exception process should be put in place for when access to a participating provider is unavailable, and implementation must include a robust communication campaign.

Mr. Costantino queried if WTW considered the global approach along with RBP. Ms. Iglesias said the presentation was prepared as a response to the Committees request for initiatives that could be adopted quickly and implemented within the authority of the Committee. She added that a global approach would take longer to implement and likely require adoption by the General Assembly. Mr. Fyock stated that global approach is more likely to be utilized when billing for out-of-network services.

Mr. Oberle stated his concern is the sustainability of the State's plan, and that RBP with the prohibition of balance billing is a responsible and reasonable option. He stated that a global budgeting solution, though longer-term should also be considered, and that a consensus at the Committee level should be laid out as a path forward for the General Assembly.

Dr. Walker agreed that the Committee should consider global budgeting, as well as ACO options. She acknowledged that long-term solutions likely extend beyond the authority of the Committee. She stated that the authority to negotiate RBP for certain procedures is limited, lacks flexibility, and is still fee-for-service, and that the Committee cannot address other market changes that may result in cost shifting.

Mr. Fyock noted that pharmaceuticals remain 20% of medical spend and solutions are complex and evolving issue.

Dir. Rentz stated there is some opportunity to address concerns in the contracting renewal process that begins July 1.

OTHER BUSINESS

Mr. Oberle encouraged all members of both Subcommittees to attend the full Committee meetings. He thanked Dir. Rentz. Dr. Walker asked the Subcommittees to consider ways to engage employees on the work being done.

PUBLIC COMMENT

Dir. Rentz noted that public comment was not planned on the agenda, but allowed it following consent of the Subcommittees.

Ms. Christina Bryan, representing the Delaware Healthcare Association, noted for the record that the presentation reflecting Christiana Care with a 17% profit is misleading, adding that after reinvestments it is 6.8% which is closer to what was presented as the national average. She added hospitals focus on health outcomes and community outreach for a healthier Delaware, and they support primary care networks in areas that are rural or low income, and do so at a loss losing millions of dollars annually. She cautioned any constraints on hospital that could negatively impact work being done within the community.

Ms. Elizabeth Lewis Zubaca, representing Christiana Care Health System ("CCHS"), also expressed concerns regarding the presentation on profit margins. She noted that in 2018 the CCHS operating margin for the hospital was 5.7% down from 8.8% in 2016. She added that CCHS is offering to bring in experts to provide context.

Mr. Chris Manning, representing Nemours AI DuPont Hospital, stated that he agrees that the long term solution is more global as we move toward value-based care. The conversation is challenging, but cautioned that the Hopkins presentation is missing context, and the missing adjustments (e.g. parity and risk) are material and cannot be understated. He added that words matter, providing "price" as an example, stating that in the presentation the word seemed to mean something different at different times. In regards to the -1% margin for efficient hospitals, he queried the definition of an "efficient hospital," adding that a hospital cannot operate for long with a negative margin and cautioned the Subcommittees not to over generalize a target margin. Dr. Bai responded that one-quarter of hospitals are defined as "efficient" by CMS. Mr. Manning continued, stating that reimbursements differ on the inpatient side versus the outpatient side, and that when discussing hospital margins, it was unclear whether that included both hospital and practice, adding that if you dig into healthcare financing you would find that those two things are managed very differently and often offset in the larger margin conversation. He challenged the Subcommittees not to lose sight of the kind of healthcare delivery system we want for Delaware. Margins are reinvested, capital projects come out of what hospitals carve out of operating margins and everyone has expectations for what they want from their hospital, and they want the best.

ADJOURNMENT

A MOTION was made by Mr. Oberle and seconded by Ms. Steward to adjourn the meeting at 4:10 p.m.
MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

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Martha Sturtevant, Statewide Benefits Office, Department of Human Resources
Recorder, Statewide Employee Benefits Committee & Subcommitees