



# **State Employees Health Plan Task Force Public Testimony Meeting**

**January 12, 2016**

# Introduction

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- Welcome
- Epilogue Language in FY2016 Budget (Section 73) created State Employees Health Plan Task Force
- Members:
  - Chair – Director, Office of Management and Budget (also Chair of State Employee Benefits Committee (SEBC))
  - Other members of SEBC (or their designees)
    - State Treasurer
    - Insurance Commissioner
    - Controller General
    - Chief Justice of the Supreme Court
    - Representative of the Correctional Officers Association
  - Representative of AFSCME
  - Representative of Delaware State Troopers Association
  - Representative of Delaware State Education Association
  - Legislators
    - Co-Chairs of the Joint Finance Committee (JFC)
    - Two representatives of minority caucus also members of JFC

# Introduction

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- Purpose: finding cost savings and efficiencies
- Areas of Inquiry: plan design, rate setting process, rates across plans, premiums based on income, cost share of premiums; increased participation in wellness programs, surcharges based on wellness activities, deductibles, high cost claims, case management, third party administrators, prescription benefits manager, centers of excellence, employee health centers, consolidation of plans, covered groups and eligibility of members, coordination of benefits, double state share, disease management and wellness outcome measures, and alternate coverage (market place, exchange and insured), and the Cadillac Tax (excise tax)
- The Task Force met bi-weekly from September 9 through December 3<sup>rd</sup>
- Report released to the Governor and legislature on December 16th
- Purpose of this meeting:
  - Receive public comment on subject of State Employees Health Plan and Task Force report

## Public Comment

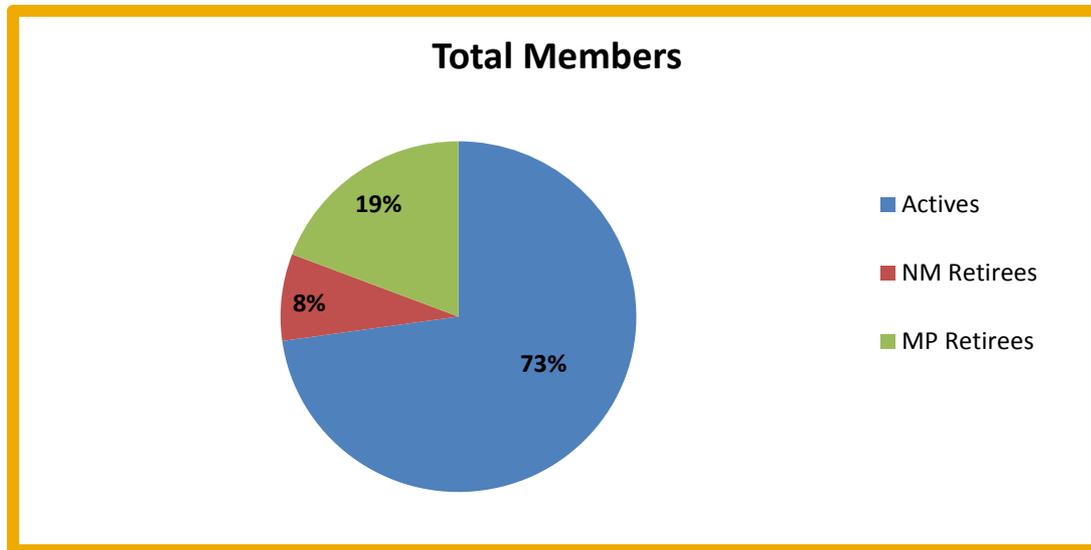
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- General process for public comment
  - During public testimony meetings
    - Individuals are allotted 3 minutes
    - Individuals representing an organization are allotted 5 minutes
  - Suggestions mailbox – [healthplan.taskforce@state.de.us](mailto:healthplan.taskforce@state.de.us)

# Group Health Insurance Plan Overview

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- The Group Health Insurance Program (“GHIP”) is available to:
  - Active Employees,
  - Non Medicare (NM) Retirees
  - Medicare Primary (MP) Retirees
- The above groups represent 67,000 contracts and just over 122,000 covered lives



Based on GHIP financial reporting through FY15  
Includes NonState group membership – 7,300 contracts/17,100 members

## Plan Overview – Understanding the GHIP Health Plans

- Health Plan Options Available to GHIP members
  - 6 active/non Medicare plans (same plans available to both groups)
  - 1 Medicare supplement plan (supplements coverage and services not covered by traditional Medicare)
  - All plans include prescription drug coverage administered by Express Scripts

	Actives	Non Medicare	Medicare Primary
<i>Premium Cost Share Percentage Split</i>	<b>State/Employee</b>	<b>State/Retiree</b>	<b>State/Retiree</b>
<b>Highmark Comprehensive PPO</b>	86.75%/13.25%	86.75%/13.25%	
<b>Highmark &amp; Aetna HMO</b>	93.5%/6.5%	93.5%/6.5%	
<b>Highmark &amp; Aetna Consumer Directed</b>	95.0%/5.0%	95.0%/5.0%	
<b>Highmark First State Basic</b>	96.0%/4.0%	96.0%.4.0%	
<b>Highmark Special Medicfill Supplement</b>			100%/0%* 95.0%/5.0%**

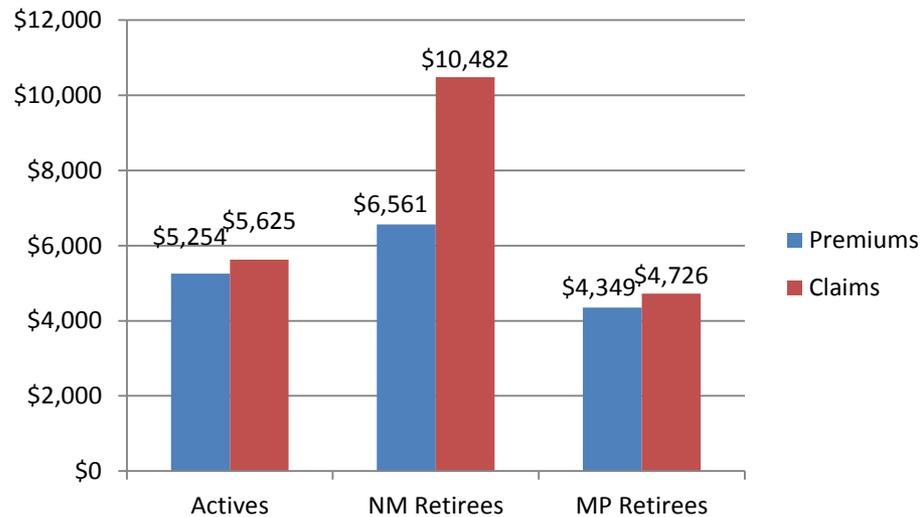
\*Retirees with full state share who retired before July 1, 2012

\*\*Retirees with full state share who retired after July 1, 2012

# Plan Overview – Understanding the GHIP Health Plan Premiums

- GHIP is self-insured for health and prescription benefits
  - Health plan premiums paid to GHIP are used to pay:
    - Actual claims incurred by GHIP members
      - Approximately 95% of total contributions are used to pay claims
    - Administrative fees to Highmark, Aetna and Express Scripts
    - Premiums are the same for actives/Non Medicare retirees
    - Per capita claims for active members are significantly less than Non Medicare Retiree members

**Per Capita Claims vs. Per Capita Premiums\***



## Historical Overview of GHIP Costs

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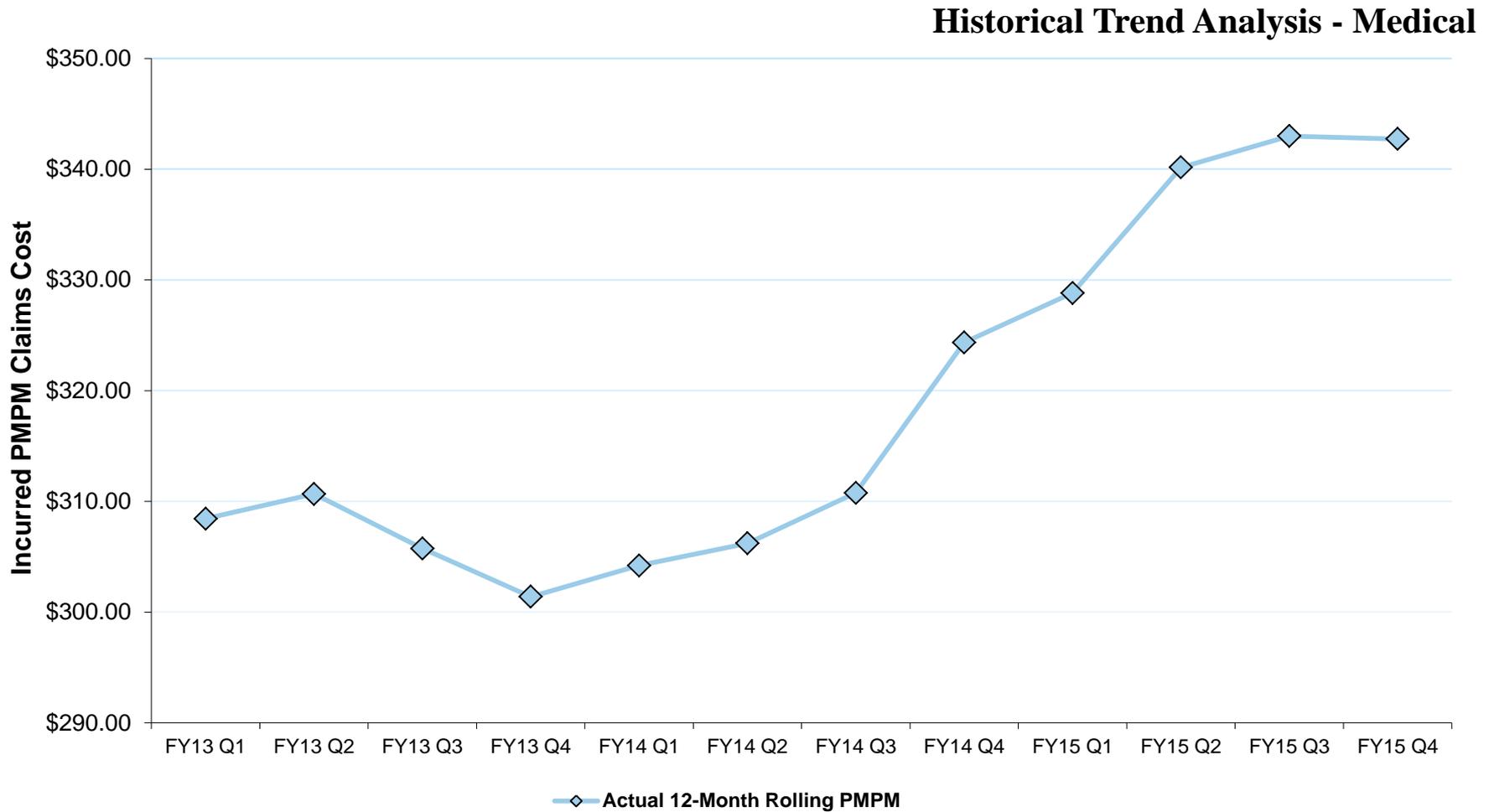
- The State Employee Benefits Committee regularly reviews GHIP costs and interested parties convened in 2011 resulting in House Bill 81 to address Health and Pension reform
- GHIP health benefit premium increases represented the largest addition to State general fund budget in FY16 - \$47.1M
  - State pays 91.4% of total health premium on average
  - Employee/Non Medicare eligible pensioners pay 8.6% of total health premium on average.
    - Employee/Non Medicare eligible pensioner premiums increased \$3.86 to \$37.46 per month effective September 1, 2015
- Challenge of managing health premium increases needed to fund rising costs accelerated in FY14
  - If costs continue to increase at rate experienced in most recent year, GHIP costs will exceed \$1 billion by FY2020

## High Level Cost Increase Overview

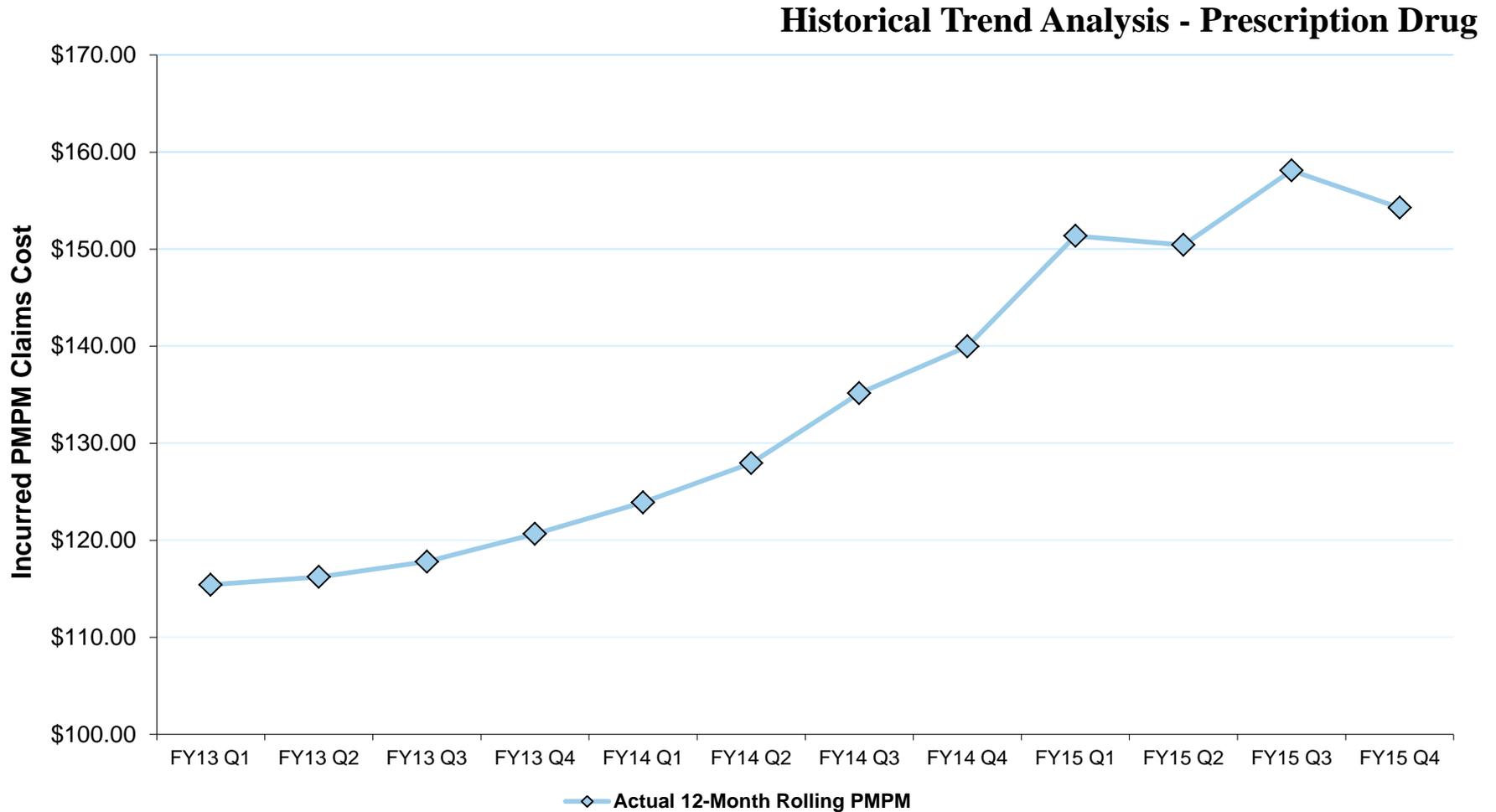
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- Sources of cost increases are driven by both medical and prescription components.
  - Number of services and medications = Higher utilization
  - Severity of the diagnosis/treatment protocol
- On the medical side:
  - Outpatient surgery
  - Inpatient hospital admissions
- On the prescription side:
  - Rising cost of brand and specialty drugs,
  - Slowdown of drugs going generic,
  - Generic costs leveling off, and
  - New costly specialty drugs including the new Hepatitis C treatments.

# GHIP Medical Costs Per Member Per Month

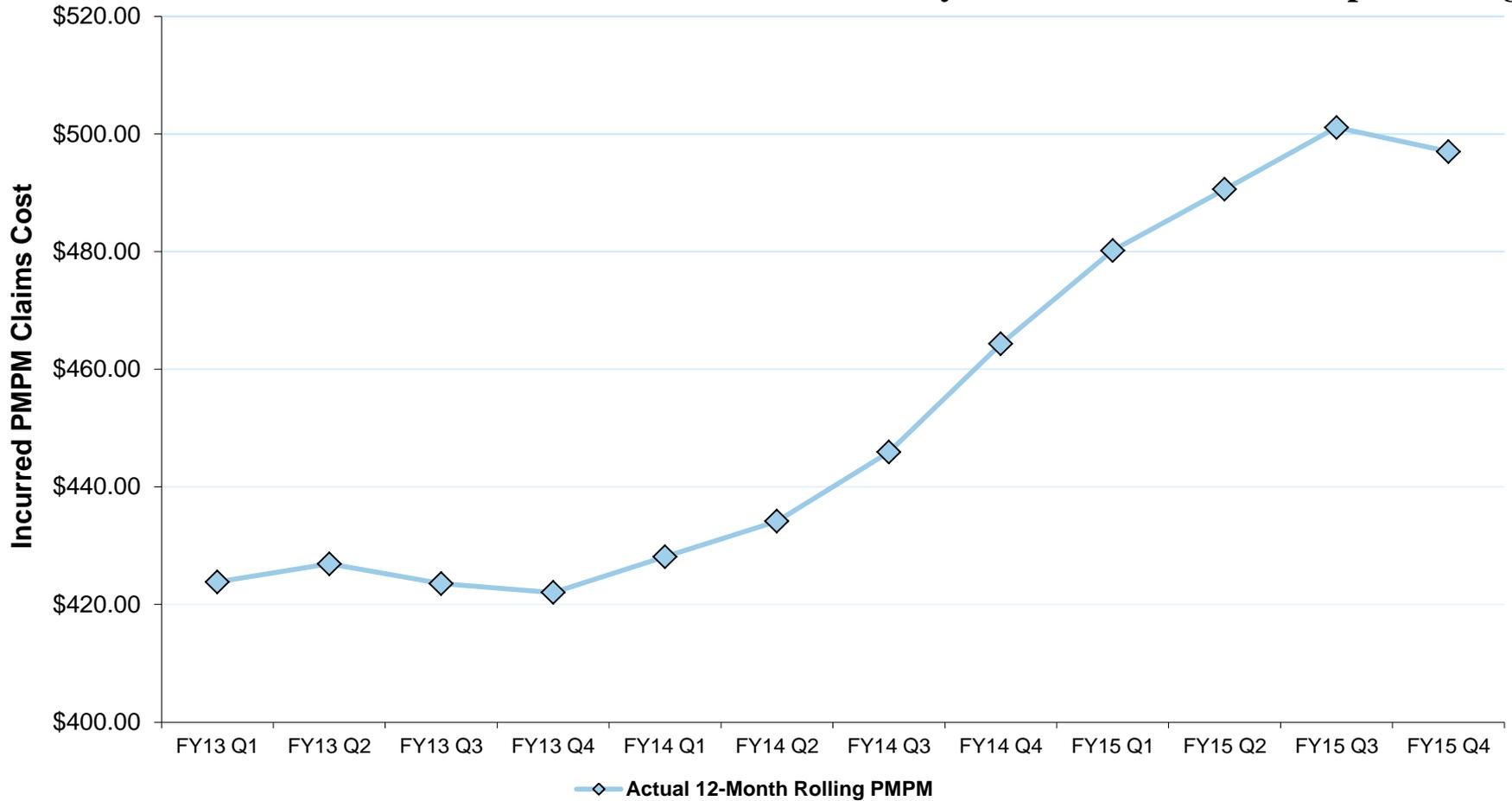


# GHIP Prescription Drug Costs Per Member Per Month



# GHIP Medical and Prescription Drug Costs Per Member Per Month

## Historical Trend Analysis - Medical and Prescription Drug



## Medical and Prescription Drug Trend – overview of current market

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- Medical costs are beginning to increase from historically low levels.
- National surveys show trend (increase in plan costs year over year) is expected to be 5.5% for medical, and 10.5% for prescription drugs, which is approximately 7% overall.

## Areas to Find Cost Savings and Efficiencies

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- Plan design
- Rate setting process
- Rates across plans
- Premiums based on income
- Cost share of premiums
- Increased participation in wellness programs
- Surcharges based on wellness activities
- Deductibles
- High cost claims
- Case management
- Third party administrators
- Prescription benefits manager
- Centers of excellence
- Employee health centers
- Consolidation of plans
- Covered groups and eligibility of members
- Coordination of benefits
- Double state share
- Disease management and wellness outcome measures
- Alternate coverage (market place, exchange and insured), and
- The Cadillac Tax/Excise tax

## Final Report Findings and Recommendations

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- The task force findings focus on:
  - Bending the cost curve to reduce GHIP's long term trend
  - Exploring opportunities to realign provider payments
  - Benchmarking GHIP plans and costs on a comparable basis
  - Improving the health of the population including enhancing member/patient understanding and usage of the healthcare system.

## Long Term Findings and Recommendations to Bend the Cost Curve

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- Finding:
  - Need for continued research, analysis and updates to consider options for impactful long term changes due to complexity of health care system.
- Recommendation:
  - Create a deep dive committee comprised of key stakeholders, e.g., legislators, leaders of the local health care system, the Governor's delegate for health policy, representatives from major payers of health care, to serve in an ongoing advisory role to the legislature and the SEBC.

## Long Term Findings and Recommendations to Bend the Cost Curve

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- Finding:
  - Members of health plan have higher health care risks associated with more frequent and more costly use of services
- Recommendation:
  - Conduct additional data analysis and benchmarking to affirm the assertion about members of the State Plan and the health of all Delawareans.
  - Gain access to provider costs to assess impact of provider pricing and contracted rates on use and costs associated with GHIP members
  - Identify opportunities for incenting wellness and health prevention among GHIP members

## Long Term Findings and Recommendations to Bend the Cost Curve

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- Finding:
  - The current plan design does not promote consumerism and/or a need to better understand the costs of care.
- Recommendation:
  - Investigate methods for promoting cost transparency for GHIP members.
  - Consider options for benefit design that creates financial incentives for members to understand the cost of care.

## Long Term Findings and Recommendations - Payments to Providers

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### ■ Finding:

- Payments to Delaware hospitals for inpatient and outpatient services represent 53.5% of the total GHIP spend (\$379 million out of \$708 total expenses in FY15). However, there is very little information available to the State explaining the payment methodology other than payments made on the basis of negotiated discounts off retail prices.

### ■ Recommendation:

- Leverage the significant contribution GHIP makes to each of Delaware hospitals' revenue to support quicker adoption of changes including provider incentives such as pay for performance and/or bundled/episodic payments that balance lower costs with improving quality of care and patient outcomes.
- Methods for exploration include reference – or metric-based pricing of services, bundled or episodic payment methods, cost-based methods (based on “true cost of care”), or even regulatory approval for payment rates. Any exploration should recognize and coordinate with findings of the Delaware Center for Health Innovation.

## Long Term Findings and Recommendations - Benchmarking

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### ■ Finding:

- Preliminary data on the value of GHIP plan of benefits suggest the plans are “richer” than those offered by peer entities. Additionally, participant contributions, which average between 9% and 10% of total GHIP expenditures, appear rich in the context of the benchmarking presented.

### ■ Recommendation:

- Pursue additional benchmarking to ensure inclusion of appropriate peers and validation of the value of plan benefits and comparability of contributions. Initiate benchmarking of the health benefits package in the context of overall compensation of the state worker, which was outside the scope of the Task Force

## Long Term Findings and Recommendations – Health Improvement

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- **Finding:**
  - The increasing risk burden and the prevalence of chronic conditions in the GHIP membership supports greater use and understanding of the programs and tools to support use of wellness and preventive services.
- **Recommendation:**
  - Explore other pricing mechanisms to encourage participation in healthy behaviors and the use of surcharges to apply to GHIP members with unhealthy behaviors, e.g., smoking, metabolic syndrome, etc.

## Short Term Findings and Recommendations – Bending the Cost Curve

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### ■ Finding:

- The number of plan options leads to confusion among members and may lead to members selecting plans that result in them “over-insuring”, selecting plans with greater value and higher contributions than needed. Over insurance may lead to continued increases in trend.

### ■ Recommendation:

- Investigate simplifying plan options and development of a best in class program with a base plan and a buy-up for those desiring additional coverage.

## Short Term Findings and Recommendations – Bending the Cost Curve

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- **Finding:**
  - Prescription drug trend is growing at a higher trend than general medical cost increases. Trend reflects both increased use as well as costs of prescription drugs. ESI presented reasonable ideas on changes for managing the prescription program for actives and retirees.
- **Recommendation:**
  - Implement ESI changes after a thorough review and vetting with the SEBC.

## Short Term Findings and Recommendations – Bending the Cost Curve

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- **Finding:**
  - Highmark, Aetna and other public employer sponsored plans have successfully used Centers of Excellence to provide savings for members and the plan while improving health outcomes
- **Recommendation:**
  - Implement programs after thorough review and vetting via SEBC.

## Short Term Findings and Recommendations – Bending the Cost Curve

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- **Finding:**

- Cost sharing by copayment, at point of care, does little to promote member interest or understanding in the cost of care.

- **Recommendation:**

- Investigate methods and ability of members to understand costs of health care to themselves as well as to the plan. Implement tools and create plan structure to drive members to most cost effective care.

## Short Term Findings and Recommendations – Payments to Providers

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### ■ Finding:

- Reference based pricing for prevalent and high cost elective procedures and diagnostic imaging have shown to have a considerable cost benefit impact in employer sponsored benefit plans, including public employers.

### ■ Recommendation:

- Investigate a pilot for a select group of high cost procedures or diagnostic tests after a thorough review of all implications.

## Short Term Findings and Recommendations – Payments to Providers

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### ■ Finding:

- Adoption of tiered network pricing for laboratory testing has led to reductions in overall outpatient laboratory spend in Highmark's book of business for their insured book of business in the state of Delaware.

### ■ Recommendation:

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## Short Term Findings and Recommendations – Payments to Providers

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### ■ Recommendation:

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## Short Term Findings and Recommendations – Payments to Providers

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### ■ Finding:

- There is a lack of transparency around provider costs as compared to charges. The Task Force pursued an approach to gain insight into provider costs and issued RFPs to conduct audits of GHIP's health plan payments to providers.

### ■ Recommendation:

- Select a firm to conduct audits of the health plans and PBM based on responses to RFP issued November 2015.

## Short Term Findings and Recommendations – Payments to Providers

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### ■ Finding:

- The use of metric based pricing with hospitals has resulted in significant savings for employers (private and public) as reported by ELAP, a firm invited to present to the Task Force and submit a proposal for services.

### ■ Recommendation:

- Consider adoption of the proposal from ELAP for data collection and analysis in support of metric based pricing.

## Short Term Findings and Recommendations – Health Improvement

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- **Finding:**
  - Chronic conditions drive a significant amount of costs in the GHIP between medical and prescription drug costs. There was general consensus among Task Force members to focus on creating plan provisions and programs that improve the health of the member. However, there was no consensus on which programs to implement.
- **Recommendation:**
  - Explore options for driving better participation and engagement in programs targeted at reducing costs and reducing the risk burden including application of surcharges and financial disincentives.

# Public Comment

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