State Employee Health Commission
Government Evaluation Report

November 1, 2009

STATE EMPLOYEE HEALTH COMMISSION
GOVERNMENT EVALUATION REPORT

Submitted to the Joint Committee on Insurance and Financial Services
November 1, 2009

A. Enabling or authorizing law or other relevant mandate, including federal mandates:

The State Employee Health Commission's enabling statute can be found in 5 MRSA § 285-A which reads as follows:

1. Establishment. *The State Employee Health Commission is established to serve as trustees of the group health plan in this subchapter and to advise the Executive Director of Health Insurance and the Director of the bureau of Human Resources on health insurance issues and the Director of Human Resources on issues concerning employee health and wellness and the State Employee Assistance Program.*

2. Membership. *The State Employee Health Commission consists of 24 labor and management members as follows:*

A. One labor member from each bargaining unit recognized under Title 26, chapter 9-B, appointed by the employee organization certified to represent the unit;

B. One labor member from the largest bargaining unit recognized under Title 26, chapter 14, appointed by the employee organization certified to represent the unit;

C. One labor member appointed by the retirees chapter of the Maine State Employees Association;

C-1. One labor member from the Maine Turnpike Authority employees appointed by the employee organization certified to represent the employees:

C-2. One labor member from the Maine Public employees retirement System employees, appointed by the employee organization authorized to represent the employees:

C-3. One labor member from the Maine Maritime Academy employees, appointed by the employee organization authorized to represent the employees;

D. Four management members appointed by the Commissioner of Administrative and Financial Services;

E. One management member appointed by the Court Administrator;

F. The executive Director of Health Insurance, ex-officio;

G. One labor member representing retirees appointed by the Maine Association of Retirees;

H. One labor member from the Maine Community College System faculty or administrative unit, appointed by the employee organization authorized to represent the units;

I. One management member from the Maine Community College System appointed by the President of the Maine Community College System;

J. One management member appointed by the Executive Director of the Maine Turnpike Authority;

K. One management member appointed by the Executive Director of the Maine Public Employee Retirement System; and

L. One management member appointed by the President of the Maine Maritime Academy.

All appointed or elected members serve at the pleasure of their appointing or electing authorities.

3. Voting. *All votes of the commission must be one vote cast by labor and one vote cast by management. The votes must be cast by the labor cochair who must be chosen by the labor members, and the vote must represent the majority opinion of the labor members of the commission, and by the management cochair who is the Director of the Bureau of Human Resources or the director's designee.*

As of October 31, 2009, the Commission membership is comprised of the following individuals:

Member	Organization	Bargaining Agent
Labor:		
Brett Hoskins, Co-chair	Maine PERS	MSEA-SEIU
Scott Kilcollins	Exec. - DHHS	MSEA-SEIU
Kandi Jenkins	Exec. - DHHS	MSEA-SEIU
Carl Parker	Exec. – DHHS	MSEA-SEIU
Steve Moore	Exec. – DOT	MSEA-SEIU
John Leavitt	Exec. - Conservation	MSLEA
Will Towers	Exec. – Corrections	AFSCME
Michael Mitchell	Exec. – Public Safety	MSTA
Cheryl Moreau	Judicial	MSEA-SEIU
John Bloemendaal	Maine CCS	MTA
Tom Hayden	Maine Turnpike Auth.	MSEA-SEIU
Sam Teel	MMA	MSEA-SEIU

Richard Hodgdon	Retirees	MSEA
Freeman Wood	Retirees	MAR

Management:

Alicia Kellogg, Co-Chair	Bureau of Human Resources
Edward Mouradian	Office of Attorney General
Rebecca Greene	Dept. of Transportation
Kimberly Proffitt	Judicial
Jan Lachapelle	Maine Community College System
Carol Harris	Maine Public Employees Retirement System
Lauren Carrier	Maine Turnpike Authority
James Soucie	Maine Maritime Academy
Frank Johnson, ex officio	Employee Health & Benefits

B. A description of each program administered by the agency or independent agency.

As trustees to the State employee health and dental plans, the Commission does not administer programs but rather serves as the body which determines benefits design (including member out-of-pocket expenses), approves of proposals as required by the competitive bid process and evaluates and selects the vendors to provide health and dental coverage.

The mission of the State Employee Health Commission is to bring labor and management together in a partnership to plan and oversee that the greatest value of health care and dental services are delivered to plan members by establishing and preserving accessible, high-quality, and affordable health care. The Commission is committed to maintaining a continuous dialogue with providers, consumers, and other organizations to identify, to measure and to influence health care services and delivery systems.

An explicit goal of the Commission is to construct a benefit design that ensures that plan expenses do not exceed the budgeted allocation for the health plan. A more implicit goal is to implement adjustments to the plan that are consistent with the value-based purchasing strategy adopted by the Commission. In recent years the Commission has been challenged by several factors. Health care inflation has increased at rate better than twice that of general inflation. The State employee plan has a significant retiree population which contributes greatly to overall plan expenses. This significant retiree population and the relatively older age of the active employees contribute to a greater prevalence of chronic illnesses such as diabetes, cardiovascular disease, chronic obstructive pulmonary disease, asthma, and low back disorders.

Despite these challenges the Commission has effectively managed the plan to contain costs while improving quality. During the past years the Commission has approved rate adjustments consistently within or below budget projections.

Period	Rate Increase
FY 2006	3.4%
FY 2007	2.0%
FY 2008	4.0%
FY 2009	4.4%
FY 2010	6.0%

It should be noted that the 6.0% increase for FY 2010 is largely attributable to a group of high cost claims. Eight claims accounted for nearly five million in expense in calendar year 2008.

The State employee health plan provides coverage for approximately 40,500 covered lives. Approximately 29,000 active employees and their dependents are enrolled in a point-of-service (POS). An additional 4,400 non-Medicare retirees and their dependents are also enrolled in the POS plan. The POS plan is self-insured with Anthem Blue Cross Blue Shield serving as the plan's third party administrator. Further, there are slightly more than 7,000 Medicare eligible retirees and their dependents enrolled in a Medicare Advantage Private Fee-for-Service (PFFS) plan. Through calendar year 2009 the Medicare PFFS plan will be fully insured by Coventry. Effective January 1, 2010 Anthem will be insuring the PFFS plan.

The Commission also serves as trustees to the State employee group dental plan. Eligibility for the dental plan is open to all active employees. The dental plan, insured by Northeast Delta Dental (NEDD), provides for three-levels of coverage: non-participating dentists, Delta participating dentists, and preferred (DPO-ME) providers. Current enrollment in the dental plan is roughly 15,300 employees and additional 14,400 dependents.

Although not expressly prescribed by statute the Commission has also served in an advisory capacity for the development and selection of several voluntary benefit programs including long term care and vision benefits.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating the lines of responsibility.

The Commission does not function as an operating agency therefore there is no position count or organizational flow chart. The group health and dental plans and related benefits are administered by the Office of Employee Health & Benefits.

D. Compliance with federal and state health & safety laws, including the Americans with Disability Act, the federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

Although not an employing agency (therefore not subject to federal and state employment, health and safety, ADA, equal employment and workers' compensation

provisions), the Commission requires that all vendors for contracted services comply with federal and state health and safety laws, ADA and affirmative action polices. In its role as health plan trustees the Commission is obligated to comply with the provisions of the Health Insurance Portability and Accountability Act (HIPPA) as they relate to the security of protected information.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past ten years.

The Commission does not have a budget allocation or direct funding source. The only expenses incurred by the Commission are for limited travel and meal expenses for members to travel to attend meetings as provided by statute and collective bargaining agreements. Expense reimbursement is provided through the operating budget of the State employee health insurance program's administrative budget. The Accident, Sickness, and Health Insurance Internal Service Fund provides the funding source for the administration of the health plan and related services. An administrative fee is assessed to agencies from premiums to fund this account.

At the Committee's request we can provide historical funding and expenditure information for Employee Health and Benefits and the State employee health insurance plan.

F. When applicable, the regulatory agenda and the summary of rules adopted.

The only rules which the Commission has adopted are for the conduct of member appeal hearings as required by 5 MRSA, § 286. The *Rules of Practice for Governing Adjudicatory Proceedings of the State Employee Health Commission* were promulgated in 1989 in accordance with the Administrative Procedures Act.

These rules govern the procedures for administrative hearings to include: notice, evidence, presiding officers, decisions, and representation before the Commission. The rules provide for two levels of appeal on health insurance matters. An appeal panel designated by the Commission hears and rules on cases related to covered services, eligibility and contract administration. A dissatisfied party may appeal to the entire Commission for reconsideration.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative agreements, including, but not limited to, cooperative agreements to coordinate services and eliminate redundant requirements.

The only agency with which the Commission maintains a working relationship is the Office of Employee Health & Benefits which administers the group health and dental plans. In order to provide for efficient operations related to enrollment, billing, premium payments and other administrative services the Office of Employee Health & Benefits

must maintain a collaborative relationship with all line agencies in the executive branch as well as "ancillary" organizations such as the Maine Public Employees Retirement System, the Maine Community College System, the Maine Turnpike Authority, etc.

H. Identification of the constituencies served by the agency or program, noting any changes or potential changes.

The constituencies served by the Commission are those employees and retirees eligibility for participation in the State employee health plan as defined by 5 MRSA, § 285.1. Presently, eligibility is provided for: appointed or elective officers or employees of the Legislative, Executive and Judicial branches, the Maine Public Employees Retirement System, the Maine Community College System, the Maine Turnpike Authority, the Maine Maritime Academy, and several smaller boards, commissions, and quasi governmental organizations. Additionally, two non-governmental groups are eligible: blind persons operating a facility under the Department of Labor, Division for the Blind and Visually Impaired and licensed foster parents caring for children whose care is reimbursed through the Department of Health & Human Services.

Retiree eligibility is afforded to those retired employees of the aforementioned organizations.

Since eligibility is prescribed by statute the Commission's constituency is not likely to be altered significantly.

I. A summary of efforts by agency or program regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives.

The Commission relies on the Office of Employee Health & Benefits to implement and administer service delivery. In order to maximize resources the Office of Employee Health & Benefits contracts with private organizations to provide services such as management of a claims database and the reports and analysis associated with that database, and benefit consulting and actuarial analysis.

In order to improve the communications with members and reduce the reliance on direct mail the Commission has increased the use of the Office of Employee Health & Benefits website and introduced a quarterly newsletter. These changes were made to improve efficiency but also to provide alternate media to a very diverse membership.

J. Identification of emerging issues for the agency or program in the coming years.

Like any large plan sponsor, the Commission will be confronting a dynamic health care market in an economy where the pressure to contain costs is exacerbated. In addition to the factors affecting the general Maine market the Commission will continue to be challenged by issues somewhat unique to the State employee plan. The active employee population has a higher disease burden compared with other larger employers. That translates into greater per member expenses. The State employee population is comprised

of any aging workforce with a substantial segment eligible and poised to retire in the next several years. In recent years the active employee population has declined while the retiree population has continued to grow.

The non-Medicare population has increased as a percentage of the POS enrollment. That in itself is not problematic but the fact that this group routinely has a per member cost that is nearly 2 ½ times that of actives will have a significant impact on overall plan expenses. Much of this per member cost differential is attributable to the higher prevalence of chronic illness. Non-Medicare retirees have three times the rate of diabetes and over four times the rate of coronary artery disease as active employees. As the non-Medicare population expands, so too will plan expenses.

The Medicare retiree enrollment is also increasing and it is expected that trend will continue in the foreseeable future. While the State employee plan is effectively the secondary payer for Medicare retirees resulting in premium rates that are currently about 40% of the POS rates, the potential for lower Medicare reimbursement rates poses challenges. There is a large degree of uncertainty about the future of Medicare Advantage plans and how they may evolve in Maine.

Looming over the issues of retiree health benefits is the ominous liability of the GASB 45 actuarial valuation. The actuarial accrued liability State employee retiree health was valued at $1.2 billion at the end of FY 2008. While the Legislature and the Administration have taken positive action to allocate funds for plan assets to address this liability, current economic conditions preclude much advancement on that investment.

There are other issues with broader implications that will also affect the State employee health plan. There are three external factors which have and will continue to influence the Commission's activities. First, there have been several compelling studies revealing that slightly over half of the adult Americans with chronic illnesses are receiving recommended, appropriate treatment. Second, there has been a series of analyses concluding that between 30-40% of the direct health care expenditures in the nation are attributable to poor quality and waste.

A third (and related) factor has been the growing acceptance of the analysis of the Dartmouth Institute defining three categories of health care services. Supply sensitive care is the largest category in terms of expense and offers the greatest opportunities to eliminate waste. These services are often widely variable, not determined by scientific evidence and related to chronic illnesses - physician visits, diagnostic tests, and hospitalizations. Studies have revealed that excessive use of these services often does not produce corresponding clinical value.

Preference-sensitive services are defined as care for conditions for which there are multiple proven treatments with significant tradeoffs that may affect patients' quality and/or length of life. Examples include early stage breast cancer or prostate cancer. There may be several treatment options with similar outcomes. Treatment choices should reflect the preference of the patients but often do not. Finally, the third category of care is

effective care, services of proven value where the benefits outweigh the risks for virtually all patients. The use of beta blockers for heart attack patients and surgery for hip fracture are examples of effective, evidence-based care.

These findings have contributed greatly to the call for serious payment reform in health care – to move from paying for volume to paying for outcomes and improved health. The Commission is pursuing strategies that will link payment reform and benefit design to the Dartmouth Institute findings. The payment model that the Commission is examining would provide for global budgets or capitation to reimburse providers for supply sensitive services while introducing higher copays for members. For preference sensitive care providers would be reimbursed for delivering informed, evidence based choice and patients would experience lower out-of-pocket expenses if they engaged in shared decision-making. With effective care the model would reimburse providers fee-for-service with incentive payment for outcomes results. Cost barriers would be removed for patients and in some instances incentives would be offered for compliance.

The Commission continues to partner with the Maine Health Management Coalition in defining payment reform strategies that will produce sustainable change. That partnership includes support for the Patient-Centered Medical Home, the development of accountable care organizations (ACOs), and the pursuit of pilot projects to test the theories of new payment models.

While an end to the reliance on the current fee-for-service system is a significant departure in provider payment, the Commission has successfully tested the value-based benefit design theory. In 2005 a demonstration project was implemented to improve the care of members with diabetes. The Telephonic Diabetes Education & Support (TDES) program was designed to encourage members with diabetes to engage in an education and self-management program. Convenience barriers were removed by providing that 10 of the 12 consultations with certified diabetes educators could be completed by phone rather than a classroom setting. Further, the plan waived the copays for all diabetic medications and supplies for the duration of the member's participation in the program.

The participants of the demonstration project were compared with randomly selected control group. Findings revealed that project participants were more likely to receive recommended care, had better biometric results (improved lipid, blood sugar, and blood pressure levels), and exhibited far greater medication adherence. Additionally the preliminary analysis has indicated an average annual reduction of $1,300 per participant. Reduced costs for emergency room visits and hospitalizations significantly offset the increased costs associated with more physician visits and the prescription drug copay waiver.

The early return on investment analysis of the tiered hospital benefit is encouraging but not as conclusive as the TDES project. Although the cost savings of the tiered hospital benefit are more elusive than other initiatives, there is strong evidence to support the argument that this effort has improved overall quality and value. One of the measures of patient safety that has been used by the Commission is the results of the Maine Health

Management Coalition's medication safety survey. In 2005 the average score of the survey was 14. By 2009 the average score had risen to 73 and every Maine hospital had achieved blue ribbon status in patient safety.

Another key measurement of Maine hospital performance has been the comparison with national results for Centers of Medicare and Medicaid (CMS) indicators. CMS reports on hospital performance in four clinical areas: treatment of heart attack, heart failure, pneumonia and surgical infections. Maine hospitals continue to exceed the national performance even as national averages have increased. Based on the most recent data the statewide averages for the treatment of heart attack and surgical infections are only slightly below the performance of the top hospitals in the country. The Commission does not take credit for this improvement but public reporting and the tiered benefit design have contributed to ongoing performance improvements, individually and collectively.

The Commission has based member financial incentives exclusively on patient safety and clinical quality information. As soon as 2010 cost and efficiency will need to be added to the equation in order to reflect true value. There will be a sustained demand for greater transparency in comparative quality and cost information. Expanded access to these data will help fuel payment reform and value-based benefits. In response to feedback from constituencies the Commission is sensitive to the need to measure and report quality and cost at the service level. Rather than base decisions on general performance, members are more interested in accessing information related to specific conditions – obstetrics, orthopedics, cardiology, etc.

Even in the absence of severe budget constraints the Commission will continue to confront the challenge of containing cost growth. The health plan will be challenged to develop new strategies and to introduce innovations in order to maintain a robust benefit package for an aging workforce and growing retiree population. Large purchasers like the State of Maine must support payment reform that encourages re-engineering of health care delivery for better outcomes and improved efficiencies.

K. Any other information specifically requested by the committee of jurisdiction.

No specific information was requested.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.

As a public sector employer the State of Maine is exempt from the federal provisions of ERISA. In the judgment of the Bureau of Insurance, the State's status as a self-insured employer places the State employee health plan under the laws and rules governing an insurer offering an HMO product.

M. Agency policies for collecting, managing and using personal information over the Internet and non-electronically, information on the agency's implementation of

information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The use and protection of client information is strictly prescribed by the Health Insurance Portability and Accountability Act (HIPAA). All other information technology policies are governed by the polices and practices of the Department of Administrative & Financial Services.

N. A list of report, applications and other similar paperwork required to be filed with the agency by the public. The list must include:

(1) The statutory authority for each filing requirement;

(2) The date each filing requirement was adopted or last amended by the agency;

(3) The frequency that filing is required;

(4) The number of filings received annually for the last 2 years and the number anticipated to be received annually for the next 2 years; and

(5) A description of the actions taken or contemplated by the agency to reduce filing requirements and paperwork duplication.

This section does not apply.