

ATTACHMENT H

633 A.2d 369, 1993 WL 370851 (Del.Sup.)
 (Table, Text in WESTLAW), Unpublished Disposition
 (Cite as: 633 A.2d 369, 1993 WL 370851 (Del.Sup.))

H

(The decision of the Court is referenced in the Atlantic Reporter in a 'Table of Decisions Without Published Opinions.')

Supreme Court of Delaware.
 Anthony CROOKS, Employee-Appellant,
 v.
 DRAPER CANNING COMPANY, Employer-Appellee.

No. 196,1993.
 Submitted: July 28, 1993.
 Decided: Sept. 7, 1993.

Court Below: Superior Court of the State of Delaware, in and for Sussex County, C.A. No. 92-11-002.

Superior Court, Sussex County, 1993 WL 189532.

AFFIRMED.

Before VEASEY, Chief Justice, and MOORE, and WALSH, Justices.

ORDER

WALSH, Justice.

*1 This 7th day of September, 1993, upon consideration of the appellant's opening brief and the appellee's motion to affirm pursuant to Supreme Court Rule 25(a), it appears that:

(1) This is an appeal from a Superior Court decision affirming a determination of the Industrial Accident Board ("Board") that Appellant Anthony Crooks ("Crooks") is not entitled to permanency benefits in connection with a 1986 industrial accident. On appeal, Crooks raises two claims of error: (1) hearsay evidence was improperly admitted at the Board hearing; and (2) the Board's decision is not supported by substantial competent evidence.

(2) Crooks, while employed by Appellee Draper Canning Company ("Draper"), was injured on November 8, 1986, when scaffolding collapsed. As a result, Crooks received worker's compensation benefits for injuries to his lower back until August 28, 1988, when the Board determined that the disability attributed to the work-related accident had resolved. On July 9, 1988, Crooks was involved in a non-work related automobile accident, which allegedly exacerbated his back injuries.

(3) On October 30, 1991, Crooks filed a Petition to Determine Additional Compensation Due, claiming that the injuries to his back were of a permanent nature and stemmed from his 1986 industrial accident. Following a hearing, on October 9, 1992, the Board denied Crooks' petition for permanency benefits on the basis of its August 28, 1988, decision and the testimony of Dr. Robert Varipappa, Draper's medical witness. The Board concluded that Dr. Varipappa's testimony was more credible than that of Dr. James Schreppler, Crooks' medical expert. The Board's decision was affirmed by the Superior Court and this appeal followed.

(4) In support of his hearsay claims, Crooks asserts the Board erred in allowing as evidence the medical opinions of two non-appearing physicians, over his objection. Further, Crooks asserts that the police report of the automobile accident was improperly admitted, again over his objection. In moving to affirm, Draper argues that the medical opinions were properly admitted and that the Board's findings were supported by substantial evidence. While tacitly conceding that the police report should not have been admitted into evidence, Draper argues that the report was not relied upon by the Board in its decision and thus any error in its admission was harmless.

(5) In this second stage of appellate review, the standard and scope of review of the Board's decision is governed by statute, 29 Del.C. § 10142.

633 A.2d 369, 1993 WL 370851 (Del.Supr.)
(Table, Text in WESTLAW), Unpublished Disposition
(Cite as: 633 A.2d 369, 1993 WL 370851 (Del.Supr.))

Factual determinations of the Board, if supported by substantial evidence, will not be disturbed on appeal. Rulings of law are subject to *de novo* review. *Duvall v. Charles Connell Roofing*, Del.Supr., 564 A.2d 1132 (1989).

(6) While the propriety of admitting hearsay evidence in administrative hearings presents a question not subject to easy answer, *see* Ernest H. Schopler, Annotation, *Hearsay Evidence in Proceedings Before State Administrative Agencies*, 36 A.L.R.3d 12 (1971), Delaware courts have held that administrative rulings may not rest solely upon such evidence. *Geegan v. Unemployment Compensation Comm'n*, Del.Super., 76 A.2d 116 (1950); *Barnett v. Division of Motor Vehicles*, Del.Super., 514 A.2d 1145 (1986).

*2 (7) Here, however, it is clear that the Board did not **rely solely upon hearsay evidence**. To the contrary, the Board based its findings on its August 28, 1988 decision and a variety of competent testimony presented at the hearing. Thus, the mere admission of the hearsay evidence, whether proper or improper, does not warrant **reversal**. *In re Delaware Sports Service*, Del.Super., 196 A.2d 215, 221 (1963), *aff'd*, Del.Supr., 202 A.2d 568 (1964), *cert. denied*, 379 U.S. 965 (1965); *In re Kennedy*, Del.Supr., 472 A.2d 1317, 1329, *cert. denied*, 467 U.S. 1205 (1984).

(8) Crooks' argument that the Board's decision is not supported by substantial evidence lacks merit. "Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. It is also defined as more than a scintilla but less than a preponderance of the evidence." *Breeding v. Contractors-One-Inc.*, Del.Supr., 549 A.2d 1102, 1104 (1988). The Board's decision is clearly supported by substantial evidence, to the extent the Board accepted Dr. Varipappa's opinion on the disputed issues of permanency and causation. *General Motors Corp. v. Veasey*, Del.Supr., 371 A.2d 1074, 1076 (1971), *overruled on other grounds*, *Duvall v. Charles Connell Roofing*,

Del.Supr., 564 A.2d 1132 (1989).

(9) It is manifest on the face of appellant's brief that the appeal is without merit because the legal issues on appeal are clearly controlled by settled Delaware law and there is clearly sufficient evidence to support factual determinations of the Board.

NOW, THEREFORE, IT IS ORDERED pursuant to Rule 25(a) that the judgment of the Superior Court be, and the same hereby is,

AFFIRMED.

Del.,1993.

Crooks v. Draper Canning Co.
 633 A.2d 369, 1993 WL 370851 (Del.Supr.)

END OF DOCUMENT

ATTACHMENT I

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

H

Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT
RULES BEFORE CITING.

Superior Court of Delaware.
Paul LAVELLE, Appellant,
v.
KENT COUNTY PERSONNEL
ADMINISTRATION BOARD, Appellee.

No. 96A-09-005 HDR.
Sept. 12, 1997.

Charles E. Whitehurst, Jr., of Young, Malmberg,
Whitehurst & Curley, Dover, Delaware, for
appellant.

John W. Paradee, of Prickett, Jones, Elliott, Kristol
& Schnee, Dover, Delaware, for appellee.

OPINION

RIDGELY, J.

*1 This is an appeal by Paul Lavelle ("Mr.Lavelle") from the Kent County Personnel Administration Board ("the Board") which affirmed the termination of Mr. Lavelle's employment as Deputy Chief for Kent County Department of Medical Services ("the Department"). On appeal Mr. Lavelle argues that (1) the Board committed legal error when they allowed the hearing to proceed after certain prejudicial and irrelevant information was sent to the Board, (2) Kent County made an election of remedies and therefore, could not terminate him after he was suspended or, in the alternative, it was an abuse of discretion to terminate him, (3) certain hearsay evidence was improperly admitted before the Board, (4) the findings of the Board were not supported by substantial evidence, (5) the Board erred when it stated the applicable standard of review and (6) the findings of the Board are conclusory. The Board

has responded to Mr. Lavelle's appeal and argues that (1) the materials complained of were not relied upon by the Board and therefore, the submission of these materials to the Board was harmless error, (2) Mr. Lavelle's termination was based upon different conduct than his suspension and therefore, his termination was not barred by the doctrine of election of remedies and was not an abuse of discretion, (3) hearsay evidence is admissible before the Board and since the Board's decision did not rely solely upon hearsay evidence it is without error, (4) the Board's findings of fact are supported by substantial evidence, (5) the Board did not err when they stated the standard of review and (6) the Board's decision was not conclusory and does not require remand. For the reasons stated below this Court concludes that the decision of the Board should be affirmed.

I. BACKGROUND

Mr. Lavelle was employed as Deputy Chief since November 1994. On June 11, 1996 Mr. Lavelle was suspended by Colin Faulkner ("Mr.Faulkner"), Chief of Kent County Department of Emergency Medical Services ("Chief") and Mr. Lavelle's supervisor. Mr. Lavelle was suspended for three days for violating Articles 15.52^{FN1} and 15.56^{FN2} of Kent County's Personnel Ordinance ("Personnel Ordinance"). Specifically, Mr. Lavelle's suspension notice stated that he was suspended for (1) purchasing "without establishing a cost factor, a total of \$3295.65 in wash/wax and concrete cleaners, which far exceeds the needs of this department" and (2) receiving "a gratuity of a Fischer CD/Tape Player without notifying the department head and [not attempting] to return said item to the vendor." At the conclusion of his suspension on June 14, 1996, Mr. Lavelle was placed on administrative leave, with pay, pending a comprehensive investigation of the Department's dealings with Pioneer, Inc. ("Pioneer"), the company that Mr. Lavelle bought the wash/wax and concrete cleaner from and received the Fischer CD

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
 (Cite as: 1997 WL 719134 (Del.Super.))

and cassette player ("CD player") from.

FN1. Section 15.52 states:

conduct unbecoming an employee. This shall include the following: conviction of a crime; insubordination; inefficiency and incompetency; giving false statements to supervisors or the public; acceptance of gifts, gratuities, or loans from organizations, business concerns, or individuals with whom he has official relationships on business of the County government; profane, obscene, insulting words or gestures toward the public or any County employee.

FN2. Section 15.56 states:

violation of State Statutes, County Ordinances, administrative regulations or department rules.

As a result of this investigation more excessive spending and gratuities were revealed and Mr. Lavelle was given written notification on July 10, 1996 that the County intended to terminate his employment. This letter stated that Mr. Lavelle's termination was based upon violations of Articles 15.52, 15.54^{FN3} and 15.56 of the Personnel Ordinance as well as violations of Kent County Procurement Policy P-53 ("Procurement Policy"). With respect to the Procurement Policy the violations stated in the letter were (1) ordering quantities of vehicle wash/wax/concrete cleaner far beyond immediate departmental requirements, (2) not establishing a cost factor prior to procurement, (3) misrepresenting and not being truthful or expeditious in advising the Chief of the total costs involved when the initial purchase was made, (4) not distributing the wash/wax to the southern facility, (5) failing to follow recommended procurement procedures by securing competitive price factors, (6) violating the procurement policy by fragmenting the initial purchase to disguise the totality of purchase from the Chief and to avoid

competitive pricing and (7) repeatedly accepting gratuities including a Swiss army knife, a Coleman rechargeable lantern, a Black and Decker cordless screwdriver and a CD player. This letter also stated that pursuant to Articles 14.20^{FN4} and 14.40^{FN5} of the Personnel Ordinance a pretermination hearing had been scheduled. This hearing was held on August 6, 1996 and the purpose was to allow Mr. Lavelle to respond to the stated reasons for his intended termination. Following this hearing Mr. Faulkner sent a letter to Mr. Lavelle on August 12, 1996 terminating his employment as Deputy Chief effective August 23, 1996. On August 26, 1996, Mr. Lavelle appealed the termination of his employment to the Board. The Board held a hearing on September 4, 1996 at which Mr. Faulkner testified on behalf of the County and Mr. Lavelle and Barry Everly ("Mr. Everly") testified on behalf of Mr. Lavelle.

FN3. Section 15.54 states:

abuse of County property or the use of County supplies, materials, equipment or other property for personal purposes or securing the same for others.

FN4. Section 14.20 states:

A permanent employee may be terminated immediately for any offense described in Article 15.51 to 15.58, inclusive, after the employee is afforded a pretermination hearing.

FN5. Section 14.40 states:

Pretermination Hearing-Prior to terminating a permanent employee, the Department Head shall issue written notification to the employee of the intent to terminate. Said written notification shall state the reasons why the employee is being terminated and shall include the date, time and place of a pretermination hearing between the Department Head or

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

his/her designee', and the employee in order to afford the opportunity for the employee to respond to the stated reasons for termination. A copy of said notification shall be sent to the Personnel Director.

*2 Mr. Faulkner testified that as Chief he is responsible for the operations of the entire Department. He testified that Mr. Lavelle was one of the Department's two Deputy Chiefs. He explained that he was Mr. Lavelle's supervisor and that Mr. Lavelle was responsible for the daily operations of the Department including the procurement of goods. Mr. Faulkner testified that when goods are ordered for the Department an order is placed over the phone and when the items come in they are accompanied by an invoice. Mr. Faulkner explained that anyone who works in the office can sign for goods when they are delivered. However, the person who is responsible for procuring the materials gets the merchandise and it is their job to compare the items received with the invoice. The procurement officer then gives the invoice to the department secretary and requests that she generate a requisition form requesting that a purchase order be generated which in turn will generate the check to pay for the items received. Mr. Faulkner testified that the requisition form is generated in his office and must be approved by either himself, Mr. Lavelle or Mr. Wilson. However, when the requisition form is approved the invoice is not attached. Once the requisition form is approved it is sent to the County and they pay the bill.

Mr. Faulkner testified that he first became aware of the situation with Mr. Lavelle when he was approached by Mr. McCloud, County Administrator, who expressed concern about a large purchase of car wash/wax and concrete cleaner in the amount of \$1,370.80 from Pioneer. Mr. Faulkner explained that the requisition form was approved while he was on vacation. Mr. Faulkner testified that he learned that the procurement officer

for the products was Mr. Lavelle and he had requisitioned the products. He further learned that the products were to be shipped to Mr. Lavelle. Mr. Faulkner asked Mr. Lavelle why such a large purchase of these products was made. Mr. Lavelle did not answer and Mr. Faulkner asked him if the Department would be liable for anymore of this product. Mr. Lavelle told him that the Department would receive one more bill in the amount of \$400-\$500. Mr. Faulkner explained that this was the third shipment the Department had received from Pioneer and he asked Mr. Lavelle to try to return the product. Mr. Lavelle later told him that he was able to return the concrete cleaner but not the wash/wax. Mr. Faulkner testified that he told Sharon Fox ("Ms.Fox"), the department secretary, that he needed to see everything that came in from Pioneer from that date forward. He testified that on June 5, 1996 he received a requisition in the amount of \$714.64 for what he understood was the last Pioneer invoice the Department would receive. Mr. Faulkner signed the requisition form, however, at the time he signed the form he had not seen the actual Pioneer invoice which reflected the goods that he was authorizing payment for. He testified that later in the afternoon on that same day Ms. Fox gave him an actual Pioneer invoice in the amount of \$660.66. He told her that they had just paid this and she responded that this was another invoice the Department had received from Pioneer in addition to the requisition for the invoice that he signed earlier that day. Mr. Faulkner testified that this invoice raised questions in his mind for two reasons. First, he was told by Mr. Lavelle that the Department would only receive one more shipment of wash/wax from Pioneer. Second, the invoice listed a CD player that was sent to the Department for their sole use by Pioneer free of charge. Mr. Faulkner stated that the acceptance of gratuities was against the Department's policy which was stated in the Personnel Ordinance, a copy of which Mr. Lavelle was provided with. Mr. Faulkner testified that Ms. Fox told him that the CD player was sitting in an unmarked unopened box behind Mr. Lavelle's desk and had been there for about two

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

or three weeks.

*3 Mr. Faulkner testified that on June 7, 1996 he asked Mr. Lavelle about the CD player and he confirmed that he received it but had no other explanation for the item. Mr. Faulkner also asked Mr. Lavelle why the Department received two more shipments instead of one from Pioneer and why the cost was much higher than he had predicted. Mr. Lavelle responded that he really did not know how much it was going to cost. Mr. Faulkner testified that he contacted Pioneer in order to investigate why they sent the Department the CD player. Mr. Faulkner testified that Pioneer told him the CD player was not paid for, was a promotional item and was to remain in the possession of the County. Mr. Faulkner testified that up until this point he was only aware of one gratuity, the CD player, that was accepted by Mr. Lavelle and based upon this, the excessive purchases and Mr. Lavelle's admission of not establishing a cost factor before purchasing the wash/wax, he decided to suspend him. He further testified that while Mr. Lavelle was on suspension he decided to place him on administrative leave with pay. Mr. Faulkner explained that this is not a disciplinary action since it is not grievable. Mr. Faulkner also explained that he wanted to research the Pioneer invoices to find out the extent of the dealings the Department had with Pioneer. Mr. Faulkner testified that the wash/wax that Mr. Lavelle ordered was much more expensive than the wash/wax that the Department usually ordered. He testified that in the past the Department had spent approximately \$100 a year and that Mr. Lavelle had spent over \$3000 in six months.

Mr. Faulkner testified that as a result of his investigation of the Pioneer invoices he discovered three other gratuities listed on the invoices. Mr. Lavelle was the procurement officer for the goods listed on these three invoices. The gratuities listed on the invoices were a Swiss Army knife, a Coleman rechargeable lantern and a Black and Decker cordless screwdriver. Mr. Faulkner testified that he learned that the products that were sent from

Pioneer were shipped Fed-Ex or UPS and that Mr. Lavelle did not sign for any of the items. However, Mr. Faulkner testified that Mr. Lavelle was working on the day that the products were delivered to the Department. When Mr. Lavelle was confronted by Mr. Faulkner about the gratuities he denied receiving them. Mr. Faulkner testified that as part of his investigation he called Jim Steel ("Mr.Steel") who works for Pioneer. As a result of this conversation Mr. Steel sent John Paradee, Esq. ("Mr.Paradee") a letter which stated that Mr. Lavelle had placed orders on certain dates with Pioneer and specified the invoice numbers. The letter further stated that all of the orders were verified and that all the promotional items listed on the invoices were sent. Mr. Faulkner testified that subsequent to his investigation he sent Mr. Lavelle a letter of the County's intent to terminate.

Mr. Lavelle testified that as Deputy Chief he is responsible for the procurement of materials from outside vendors. He stated that it is within his job description to order the merchandise, receive it and compare what is received with what is ordered. But, Mr. Lavelle testified sometimes other people assume this responsibility. For example, Mr. Lavelle stated that when uniforms come in Ms. Fox will "check them off." Mr. Lavelle also testified that at times Ms. Fox receives other merchandise that is ordered as well as the invoice and then she generates the requisition form without any intervention from him. Mr. Lavelle testified that in November 1995 he was contacted by Mr. Steel who identified himself as a representative of Pioneer and used Mr. Faulkner as a reference. Mr. Steel told him that he had some wash and wax products that he felt would be beneficial to the Department. Mr. Lavelle testified that he understood that the product would be \$50 per five gallon container. He ordered eight five-gallon containers since he was told that this was the appropriate amount for the number of vehicles the Department had. Mr. Lavelle testified that he told Mr. Faulkner about this purchase and he said "oh, okay." Mr. Lavelle testified that he understood that he was purchasing only \$400 of the

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

wash/wax from Pioneer. Mr. Lavelle stated that when he came back from lunch one day the first shipment of wash/wax had arrived and was sitting on the floor next to Ms. Fox's desk. However, there was no invoice with it so he just put the product initially in his office and then in the storeroom. Mr. Lavelle testified that he never compared the shipment with the invoice. Further, Mr. Lavelle testified that he never saw any of the Pioneer invoices which list gratuities prior to the time of his suspension. He also testified that the requisitions for the invoices in question state that all inquiries should be directed to S. Fox and the Director is listed as C. Faulkner and that his name does not appear on the document. However, Mr. Lavelle admitted that his name does appear on the invoices which list the gratuities and state that the products are to be shipped to him and were sold to him. Mr. Lavelle testified that he never requested, received or disposed of a Swiss Army knife, a Black and Decker cordless screwdriver or a Coleman lantern. However, he testified that he did receive a CD player and that it was shipped by itself and he never saw an invoice that referenced it. He stated that he intended to tag the CD player with a County property tag and place it in the office or in another medic unit. Mr. Lavelle testified that he did think the CD player was a gratuity even though there was no charge for it. Further, he testified that he did not know that it was a violation of the Personnel Ordinance to accept the CD player.

*4 Mr. Lavelle testified that after the initial purchase from Pioneer he was contacted again by Mr. Steel concerning concrete cleaner. Mr. Lavelle thought that he purchased 3 buckets of concrete cleaner at \$10 per bucket. However, the concrete cleaner actually cost \$10 per pound and he purchased 75 pounds. Mr. Lavelle stated that he was not in the office when the concrete cleaner was delivered, he did not sign for the product, he did not see the invoice and he did not receive a gratuity as a result of this purchase. Mr. Lavelle testified that when he was first approached by Mr. Faulkner concerning the amount that he was spending on car

wash/wax and concrete cleaner, Mr. Faulkner asked him why he was spending \$1300 on these materials. Mr. Lavelle stated that he told Mr. Faulkner that he did not spend \$1300 since he did not believe that he had spent this much. Mr. Lavelle stated that he called Mr. Steel to see if he could cancel the shipment and was told that he could cancel the concrete cleaner but not the wash/wax. However, Mr. Steel told him that the payments for the wash/wax could be broken up into two billing cycles. Mr. Lavelle explained that this was the reason that two more invoices and shipments were received from Pioneer instead of one. Mr. Lavelle told Mr. Faulkner about the bill splitting and he responded that this would be fine. Mr. Lavelle testified that he never told Mr. Faulkner that only one more bill would be received from Pioneer in the amount of \$500-\$600. Mr. Lavelle also testified that he was never given a copy of the Procurement Policy nor was there a copy in his office.

Mr. Lavelle testified that part of his job is to investigate allegations of employee misconduct. Mr. Faulkner asked him to investigate Barry Everly ("Mr. Everly"). Mr. Lavelle testified that it was his understanding that Mr. Faulkner wanted to take disciplinary action against Mr. Everly, however, Mr. Lavelle investigated Mr. Everly but did not take disciplinary action against him. Mr. Lavelle testified that disciplinary action was taken against Dave Abramson ("Mr. Abramson") at the request of Mr. Faulkner. However, Mr. Lavelle testified that he investigated the situation and found that the disciplinary action taken against Mr. Abramson was unfounded. He told Mr. Faulkner his opinion a few weeks prior to the incident at issue.

Mr. Everly testified that he has worked for 5 and 1/2 years as a paramedic with the Kent County EMS and has known Mr. Lavelle during that time. He described Mr. Lavelle as a hard and dedicated worker and he stated that he had no reason to doubt Mr. Lavelle's contention that he did not receive gratuities from Pioneer. Mr. Everly admitted that he applied for the Deputy Chief job in administration

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

and did not get it. However, he testified that he did not blame Mr. Faulkner for this and denied ever telling anyone this. He also denied telling personnel that Mr. Faulkner should not be Chief.

II. STANDARD OF REVIEW

*5 The role of this Court in reviewing the Board's decision is limited to determining whether the Board's decision is supported by substantial evidence and free from legal errors of law.^{FN6} Only where there is no substantial, competent evidence to support the Board's factual findings may this Court overturn the Board's decision.^{FN7} Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.^{FN8} Also, it is within the discretion of the Board, not the Court, to weigh the credibility of the witnesses and resolve conflicts of testimony.^{FN9}

FN6. *General Motors Corp. v. Freeman*, Del.Super., 164 A.2d 686, 688 (1969); *Johnson v. Chrysler Corp.*, 213 A.2d 64, 66-67 (1965).

FN7. *Johnson*, 213 A.2d at 67.

FN8. *Oceanport Indust. v. Wilmington Stevedores*, Del.Super., 636 A.2d 892, 899 (1994).

FN9. *Starkey v. Unemployment Ins. Appeal Bd.*, Del.Super., 340 A.2d 165, 166 (1975), *aff'd*, Del.Super., 364 A.2d 561 (1976).

III. DISCUSSION

The Board found that the sole issue before them was whether the department head failed to follow the proper procedure outlined in Article 15^{FN10} of the Personnel Ordinance. The Board found that one of the duties of Mr. Lavelle was to match invoices with deliveries. Further, the Board found that exhibits C-4, C-5, C-6, C-7, C-8 and C-13 (which were the Pioneer invoices that listed the four gratuities and the letter from Mr. Steel) establish that the products at issue were shipped to

Mr. Lavelle, including the four gratuities. Further, the Board found that Mr. Lavelle admitted that all of the products were received by the Department and that the CD player was received and placed in the vicinity of his desk. Moreover, the Board found that the actual discovery of three additional gratuities by the Department occurred after Mr. Lavelle was suspended and these items were accepted into the Department at a time when Mr. Lavelle was responsible for the procurement of goods. The Board found that Mr. Lavelle's testimony lacked credibility. Accordingly, the Board found that Mr. Lavelle engaged in numerous counts of conduct unbecoming an employee within the meaning of Article 15.52^{FN11} of the Personnel Ordinance. Further, the Board concluded that the Department Head followed the proper procedures outlined in Article 15 and upheld the termination of Mr. Lavelle.

FN10. Section 15.40 of the Kent County Personnel Ordinance states:

A permanent employee may be dismissed or demoted whenever in the judgment of a Department Head the employee has failed satisfactorily to perform his/her duties or has engaged in conduct that violates established County rules. When the Department Head decides to take such action he/she shall file with the employee, the Personnel Director, and the Personnel Administration Board a written notification containing a statement of the substantial reasons for the action. The employee shall be notified not later than five (5) working days prior to the effective date of the action. The notice shall inform the employee that he/she shall be allowed two (2) calendar weeks from the date of the notification to file a reply with the Personnel Director and the Personnel Administration Board and to request a hearing before the Personnel

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

Administration Board. The pay plan rules shall provide for changes in compensation resulting from demotions.

FN11. Article 15.52 states:

conduct unbecoming an employee. This shall include the following: conviction of a crime; insubordination; inefficiency and incompetency; giving false statements to supervisors or the public; acceptance of gifts, gratuities, or loans from organizations, business concerns or individuals with whom he has official relationships on business of the County government; profane, obscene, insulting words, or gestures toward the public of any county employee.

A. Materials Submitted to the Board

Mr. Lavelle first argues that the Board committed legal error when they proceeded with the hearing after certain evidence was submitted to the Board. The Board argues that the information complained of did not provide the basis for the Board's decision and was harmless error. Prior to the hearing before the Board, Alan Kujula, Board Secretary and Personnel Director for Kent County, submitted information packets to the members of the Board. These packets were submitted to the Board by three separate memorandum which were dated August 29, 30 and September 4, 1996. Charles Whitehurst, Esq. ("Mr.Whitehurst") wrote to Craig Eliassen, Esq. ("Mr.Eliassen"), attorney for the Board, on September 4, 1996, the date on which he received the last memorandum, and objected to certain items in the information packets. The objections raised in that letter have been raised again in this appeal.

Specifically, Mr. Lavelle argues that it was prejudicial error for the Board to have been submitted an item entitled "employee progress/continuation notes" which was dated 1995-1996 and prepared by Mr. Faulkner. These notes contain dated entries which detail "incidents" with Mr.

Lavelle. One incident detailed in these notes that Mr. Lavelle in particular objects to is the entry that states that many "big ticket" items were missing from the Department. Mr. Lavelle argues that from this entry it can be inferred that he took the big ticket items from the Department. Mr. Lavelle also objects to the admission of an arrest warrant memorandum on the ground that it is irrelevant to the proceedings before the Board. The memorandum stated that Mr. Lavelle had been arrested for official misconduct and profiteering. Mr. Lavelle also objects to this submission as being inaccurate since at the time of the hearing before the Board only one charge was pending against him and not two. Mr. Lavelle also contends that this submission was designed to convey to the Board that there were adequate grounds for his termination.

*6 In response to the letter written by Mr. Whitehurst, which raised the same objections as stated above,^{FN12} Mr. Eliassen stated at the outset of the hearing before the Board;

FN12. In the letter Mr. Whitehurst also objected to an Internal Investigation Summary that was prepared by Mr. Faulkner on the ground that it was hearsay. However, this particular objection has not been renewed on appeal. Moreover, the curative instruction that Mr. Eliassen issued to the Board also covered the Internal Investigation prepared by Mr. Faulkner.

All right. Members of the board, around 5 o'clock this evening Mr. Paradee, Mr. Whitehurst, and myself had a teleconference where we discussed some evidentiary issues, and we did reach a consensus on certain items, and I'd like to make you aware of these now.

Number one, the employee progress continuation note-I believe it's a two-page document that was forwarded by the personnel director-it's actually a three-page document-it's in your packet-that

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

should be disregarded. That document, in its entirety, is essentially out of order and ought not be considered when you deliberate.

Secondly, any reference whatsoever to the apparent fact that Mr. Lavelle has been arrested ought also be purged from your minds. That's not what we're here to concern ourselves with. This is a personnel matter, and some other proceeding that may be taking place outside the walls of this building is really not our concern.

And, thirdly, there is a summary that's called "Internal Investigation Summary," prepared by Colin Faulkner. This is also in your materials. I'm instructing you to consider the testimony of Colin Faulkner rather than the implications of the summary that he may have prepared in connection with this particular proceeding.

So just to restate that, consider what Mr. Faulkner says to you this evening as the critical evidence of what it is that he offers on behalf of the County.

Gentlemen, any clarifications?

In response, Mr. Whitehurst stated, "I think that that adequately summarizes what we agreed should be submitted to the board."

An essential element of an administrative hearing entitles a litigant to an impartial hearing before a non-biased agency.^{FN13} Therefore, administrative officials must conduct proceedings with impartiality and proper decorum.^{FN14}

FN13. *Quaker Hill v. Saville*, Del.Super., 523 A.2d 947, 966 (1987), *aff'd*, Del.Supr., 531 A.2d 201 (1987).

FN14. *Robbins v. Deaton*, Del.Super., C.A. No. 93A-05-001, Steele, J. (Feb. 7, 1994).

It is apparently the practice of the Board to receive information packets prior to a hearing in an effort to familiarize themselves with the case.

Further, Mr. Lavelle was given a chance to submit materials in advance of the hearing but chose not to. Most importantly, Mr. Lavelle was given an opportunity to object to any information in the packets. This objection formed the basis for the curative instruction that was given to the Board by Mr. Eliassen. This instruction clearly stated that the items that Mr. Lavelle objected to were not to be considered by the Board in their deliberations. Moreover, it is evident from the written opinion of the Board that they did not base their decision upon any of the evidence that Mr. Lavelle objects to. It is clear from the contents of the curative instruction as well as the opinion of the Board that Mr. Lavelle was afforded a fair and impartial hearing before the Board and that none of the evidence he objects to was considered by the Board in their decision.

B. Election of Remedy and Abuse of Discretion

*7 Mr. Lavelle next argues that the County elected the remedy of suspension and is barred from terminating him for the same conduct. The Board responds that Mr. Lavelle's termination was based upon different conduct than was his suspension and therefore, the County was not barred from terminating him. The doctrine of election of remedies is based on 'any decisive act of a party, with knowledge of his rights and of the facts, indicating an intent to pursue one remedy rather than the other.'^{FN15} A party is said to have elected a remedy when he makes any decisive act, 'with knowledge of his rights and of the facts, indicating an intent to pursue one remedy rather than the other.'^{FN16}

FN15. *Wilson v. Pepper*, Del.Super., C.A. No. 90C-MY-16, Steele, J. (May 3, 1991) (quoting 28 C.J.S. *Election of Remedies*, § 11 at 1077 (1941)).

FN16. *Scott v. City of Harrington*, Del.Ch., C.A. No. 842, Jacobs, V.C. (April 14, 1986) (citing *Stoltz Realty Co. v. Raphael*, Del.Supr., 458 A.2d 21, 23) (quoting 28 C.J.S. *Elections of Remedies*, § 11 at 1077).

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

Mr. Lavelle was suspended for purchasing without establishing a cost factor wash/wax and concrete cleaner in the amount of \$3295.55 which was beyond the Department's needs. Mr. Lavelle was also suspended for receiving a gratuitous CD player. Some of the reasons for Mr. Lavelle's termination seem to overlap with the reasons for his suspension. Mr. Lavelle was terminated for ordering quantities of wash/wax and concrete cleaner far beyond the Department's immediate means. However, the amount in the letter of termination is \$3,570.35 which is higher than the amount in the suspension notice. This number is higher since after Mr. Lavelle's suspension Mr. Faulkner was able to confirm the number by reviewing all of the invoices from Pioneer which he had not previously seen. Further, the notice of termination is similar to the suspension since it lists the receipt of a gratuitous CD player. However, the notice of termination also lists the receipt of three other gratuities which were discovered by Mr. Faulkner after Mr. Lavelle's suspension when he reviewed all of the Pioneer invoices. Moreover, Mr. Faulkner explained the difference in the suspension and the termination of Mr. Lavelle when he stated, "[t]he critical difference in the termination and suspension is that we discovered that there were other gratuitous items that were accepted, signed for, into the department, that has proven out to be approved by Mr. Lavelle before they were sent."

Although the three other gratuities were shipped into the Department prior to Mr. Lavelle's suspension, Mr. Faulkner nor any other administrative official knew this. Mr. Lavelle argues that the officials had constructive notice of the receipt of these three other gratuities. However, what is important is when the officials had actual knowledge of the receipt of the three additional gratuities.^{FN17} The County was not barred from terminating Mr. Lavelle for the additional conduct which they only became aware of after Mr. Lavelle was suspended.^{FN18}

FN17. See *Werner v. Macomb County*

Council Service Comm'n, Mich.Ct.App., 77 Mich.App. 533, 258 N.W.2d 549 (1977) (looking to the time when the Sheriff had actual knowledge of the employee's conduct to determine if the charges should be dismissed) (emphasis added).

FN18. Cf. *Department of Health & Social Services v. Weiss*, Del.Super., C.A. No. 92A-02-010, Barron, J. (Jan. 15, 1993) (affirming the decision of the State Personnel Commission which held that the employer, who had entered into a settlement agreement with the employee could not later bring charges against the employee since it was clear from the settlement agreement that the employer knew of all of the conduct of the employee when the agreement was entered into).

In the alternative, Mr. Lavelle argues that even if the County had not elected the remedy of suspension, the County abused its discretion in terminating him. The choice of a penalty by an administrative agency if based on substantial evidence and not outside its statutory authority is a matter of discretion to be exercised solely by the agency.^{FN19} In reviewing the punishment for abuse of discretion, the question is whether the punishment is so disproportionate to the offense in light of the circumstances as to be shocking to one's sense of fairness.^{FN20}

FN19. *Warmouth v. State Board of Examiner in Optometry*, Del.Super., 514 A.2d 1119, 1123 (1986).

FN20. *Id.*

*8 As discussed more fully below, I find that all of the findings of the Board are supported by substantial evidence. Further, Article 15 .40 states that a permanent employee may be terminated for failing to satisfactorily perform his job or violating County rules. Moreover, Article 15.52 states that an employee may be disciplined for conduct

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

unbecoming an employee including, accepting gratuities and giving false statements to supervisors. Also, the County's choice to terminate those employees who do not follow established rules in performing their job and who repeatedly accept gratuities against established policy, does not shock this Court's conscience.

C. Hearsay

Next, Mr. Lavelle argues that the letter that was sent to Mr. Paradee from Mr. Steel is hearsay and was improperly admitted before the Board. The Board asserts that hearsay evidence is admissible before the Board and that their decision did not rely solely upon this evidence and therefore, was without error. The letter discusses the order history of the Department with Pioneer. The letter states the date on which Mr. Lavelle placed orders with Mr. Steel and specifies the corresponding invoice numbers. The letter further states that, "[a]ll of the above orders were verified with our shipping department, at which time address, unit price, item, quantities, product, promotional terms, total cost and billing terms [are] confirmed ..."

'Administrative boards are not governed by the strict evidentiary rules which govern jury trials. On the contrary evidence which could conceivably put a light on the controversy should be heard.'^{FN21} However, administrative rulings may not rest solely upon hearsay evidence.^{FN22}

FN21. *Singletary v. Townsends, Inc.*, Del.Super., C.A. No. 94A-09-005, Graves, J. (May 30, 1995) (quoting *Sawyer v. New Castle County*, Del.Super., C.A. No. 81A-JL-4, Walsh, J. (Aug. 11, 1982), *aff'd*, Del.Supr., No. 266, (April 8, 1983).

FN22. *Crooks v. Draper Canning Co.*, Del.Supr., 633 A.2d 369 (table), 1993 WL 370851.

The Board concluded that "[e]xhibits C-4, C-5, C-6, C-7, C-8, and C-13 establish that the products at issue were shipped to the Appellant, including

the four (4) gratuities." Exhibits C-4 through C-8 are the invoices which specify the products bought and the gratuities sent by Pioneer. These invoices list Mr. Lavelle as the person to whom the products were sold and the person to whom the products and the gratuities were shipped. Exhibit C-13 is the letter written by Mr. Steel. However, it is clear that the Board did not rely solely upon Mr. Steel's letter in concluding that the products and gratuities in the Pioneer invoices were shipped to Mr. Lavelle. Since the Board's decision did not **rely solely** upon the **hearsay** evidence, the mere admission of **hearsay** evidence does not warrant **reversal**.

D. Substantial Evidence

Next, Mr. Lavelle argues that the findings of the Board are not supported by substantial evidence. First, the Board found that one of the duties of Mr. Lavelle was to match invoices with deliveries as part of his property procurement responsibilities. Mr. Faulkner testified that this was one of Mr. Lavelle's duties. Moreover, Mr. Lavelle confirmed this. Although Mr. Lavelle stated that this duty was sometimes assumed by Ms. Fox, he maintained that this was not in her job description but was in his. This finding of the Board is supported by substantial evidence.

*9 Second, the Board found that exhibits C-4, C-5, C-6, C-7, C-8 and C-13 establish that the products at issue were shipped to the Appellant, including the four gratuities. As discussed above, exhibits C-4 through C-8 are the Pioneer invoices which state that the products were sold to Mr. Lavelle and the products and gratuities were shipped to Mr. Lavelle. These invoices list the products that were ordered and the gratuities that were received. Further, the letter written by Mr. Steel also states that the products were sold to and shipped to Mr. Lavelle. Further, the letter also states that the gratuities listed on the invoices were shipped to Mr. Lavelle. There is substantial evidence in the record to support this finding.

Further, the Board found that Mr. Lavelle admitted to receiving all of the products and that

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
 (Cite as: 1997 WL 719134 (Del.Super.))

the CD player was received and placed in the vicinity of his desk. Mr. Paradee asked Mr. Lavelle about the wash/wax that he ordered from Pioneer. Specifically, Mr. Paradee asked Mr. Lavelle, "And you acknowledge that at least eight were received by the department?" Mr. Lavelle responded, "I know that there were six that were received, because I placed them in my office until the supply room was cleaned up. Then they were placed in the supply room, yes, and then there were [three concrete cleaner] that arrived, and they were placed in the supply room." Also, Mr. Eliassen asked Mr. Lavelle, "[a]ll of these invoices from Pioneer Products, they're admitted as C-4 through C-8 inclusive. Were you aware when the shipments themselves arrived, any of them?" Mr. Lavelle responded, "[y]es. I came back from lunch one day when the first shipment came, and there were six containers. And like I said, they were sitting by the department secretary's-by her desk." Then Mr. Eliassen asked, "[d]o you recall if any of the later [Pioneer] shipments arrived at EMS?" Mr. Lavelle responded, "[t]he concrete cleaner-I was advised the concrete cleaner was in the supply room." Mr. Eliassen asked, "[h]ow about any of the other [Pioneer] shipments?" Mr. Lavelle answered, "I don't recall being there when there were any other shipments." Mr. Eliassen asked, "[d]id the products ultimately make their way into the supply room in all other cases?" Mr. Lavelle responded, "[y]es." Also, Mr. Whitehurst asked Mr. Lavelle about the CD player. He asked, "[n]ow you did receive a tape player." Mr. Lavelle responded, "[y]es." Mr. Whitehurst asked again, "or a cassette or a CD, whatever it is; correct?" Mr. Lavelle again answered, "[y]es, that is correct." Mr. Whitehurst asked, "[a]nd what did you do with it when you received it?" Mr. Lavelle responded, "[i]t was placed in my office." It is evident from the testimony that was heard by the Board that there is substantial evidence to support the finding that Mr. Lavelle admitted that all of the products^{FN23} that were ordered from Pioneer were received by the Department. Further, the record contains substantial evidence to support the finding that Mr. Lavelle

admitted to receiving the CD player and putting it in the vicinity of his desk.

FN23. Mr. Lavelle argues that the Board found that he admitted to receiving all of the gratuities. However, all that the Board found was that he admitted to receiving all of the products and one gratuity, the CD player.

*10 Next, the Board found that actual discovery of the three additional gratuities by the department head occurred after Mr. Lavelle was suspended. Mr. Faulkner testified that after he discovered the receipt of the CD player by Mr. Lavelle he suspended Mr. Lavelle and then placed him on administrative leave so that he could research the Pioneer invoices and get a full understanding of the Department's dealings with Pioneer. Mr. Faulkner testified that as a result of this investigation he discovered three additional Pioneer invoices where Mr. Lavelle was the procurement officer. Mr. Faulkner testified that these three invoices each listed a gratuity, namely, a Swiss Army knife, a Coleman rechargeable lantern and a Black and Decker cordless screwdriver. Mr. Faulkner also explained that when the requisitions were signed authorizing payment for the products which were listed on the invoices, the invoice was not attached to the requisition. There is substantial evidence to support the finding that the three additional gratuities were not discovered by Mr. Faulkner until after Mr. Lavelle was suspended.

Last, the Board found that the gratuities were shipped into the Department at a time when Mr. Lavelle was responsible for the procurement of goods and services. Mr. Lavelle testified that one of his responsibilities was to procure goods and services for the Department. Further, it is evident from the date on the invoices, which list the gratuities, that Mr. Lavelle was still employed as Deputy Chief when the items were shipped to the Department. There is substantial evidence to support this finding. Moreover, I conclude that all of the findings of the Board are supported by

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

substantial evidence.

E. The Board's Standard of Review

Mr. Lavelle next argues that the Board erred when they stated their standard of review. In their decision the Board stated, "[a]ppellant offered no evidence that the adverse personnel action was based on political, religious, or racial prejudice or sex discrimination. The sole issue before the Board, therefore, is whether the department head failed to follow the proper procedure outlined in Article 15 of the Kent County Personnel Ordinance." Mr. Lavelle argues that it is evident from the Board's stated standard of review that the Board factually determined that he committed acts unbecoming an employee and that the only issue was to determine if the proper procedure had been followed.

Article 16.10 states, "[i]f the Board finds the adverse personnel action was based on political, religious, or racial prejudice or sex discrimination, or that the Department Head failed to follow the proper procedure outlined in Article 15, the employee shall be reinstated to his former position without loss of pay." Article 15.40 states in part that, "[a] permanent employee may be dismissed or demoted whenever in the judgment of a Department Head the employee *has failed satisfactorily to perform his/her duties or has engaged in conduct that violates established County rules ...*" (emphasis added).

*11 When these two Articles are read in conjunction it is clear that the Board's standard of review does not assume that Mr. Lavelle committed acts unbecoming an employee and that the Board was not solely concerned with the procedural aspects of Mr. Lavelle's termination. This is because Article 15.40 states that an employee may be dismissed if the employee has failed to satisfactorily perform his duties or has engaged in conduct that violates County rules. In determining whether proper procedures were followed by the Department Head in terminating the employee, the Board must review the evidence to see if it supports the finding that the employee did fail to

satisfactorily perform his job or violate a County rule. This is necessary in determining whether the employee should have been dismissed and therefore, whether the Department Head followed proper procedure. This is exactly what the Board did here. The Board heard testimony from Mr. Faulkner, Mr. Lavelle and Mr. Everly concerning the performance of Mr. Lavelle's job as well as the violation of County rules. This was done in an effort to determine if the Department Head was justified in terminating Mr. Lavelle. The Board had to do this since, as correctly stated in their opinion, this is part of their standard of review as stated in Article 15.40. Mr. Lavelle's argument that the Board only looked to see if the proper procedure was followed is without merit. Mr. Lavelle had a full hearing where the focus was to determine if Mr. Lavelle satisfactorily performed his job or violated any rules and therefore, whether his termination was appropriate. I find that the Board correctly stated their standard of review which directly encompasses within it a review of the evidence to determine if the termination was justified.

F. Conclusory Opinion

Last, Mr. Lavelle asserts that the Board found that he engaged in numerous counts of conduct unbecoming an employee. As Article 15.52 indicates, there are numerous types of conduct which can be considered conduct unbecoming an employee under the Personnel Ordinance. Mr. Lavelle argues that he cannot tell from the decision of the Board which conduct unbecoming an employee he committed under 15.52 and therefore, the decision of the Board is conclusory.

However, it is obvious from the testimony before the Board and the decision of the Board which conduct in Article 15.52 is applicable here. There was a great deal of testimony concerning the four gratuities that were listed on the Pioneer invoices. Also these invoices listed Mr. Lavelle as the person who ordered the goods as well as the person to whom the goods and the gratuities were

Not Reported in A.2d, 1997 WL 719134 (Del.Super.)
(Cite as: 1997 WL 719134 (Del.Super.))

shipped. Moreover, the Board found that the invoices and the letter from Mr. Steel establish that the products at issue were shipped to Mr. Lavelle, including the four gratuities. Further, there was also testimony about the statements that Mr. Lavelle made to Mr. Faulkner concerning the amount of shipments that the Department would receive from Pioneer and the cost of this shipment. Mr. Faulkner testified that two more shipments were received from Pioneer and not one as Mr. Lavelle had told him. Mr. Faulkner also testified that the amount that the Department owed Pioneer as a result of these two shipments was above the amount that Mr. Lavelle told him was owed. This was reflected in the Board's decision which stated that Mr. Lavelle's statements lacked credibility including the statement about the number of shipments. Therefore, it is obvious from the testimony and the Board's opinion that the conduct applicable in Article 15.52 is accepting four gratuities and making false statements to supervisors.

END OF DOCUMENT

IV. CONCLUSION

*12 Based upon the reasons stated in this opinion I find that Mr. Lavelle was afforded a fair and impartial hearing before the Board, that the County did not elect the remedy of suspension and that the decision to terminate him was not an abuse of discretion. Further, I find that the Board did not rely solely upon hearsay evidence in their decision and that their decision was supported by substantial evidence and was not conclusory. Lastly, I find that the Board correctly stated their standard of review which required them to review the facts to determine whether Mr. Lavelle's termination was proper.

Accordingly, the decision of the Kent County Personnel Administration Board is **AFFIRMED**.

IT IS SO ORDERED.

Del.Super.,1997.
Lavelle v. Kent County Personnel Admin. Bd.
Not Reported in A.2d, 1997 WL 719134
(Del.Super.)

ATTACHMENT J

Not Reported in A.2d, 1997 WL 819110 (Del.Super.)
(Cite as: 1997 WL 819110 (Del.Super.))

H

Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT
RULES BEFORE CITING.

Superior Court of Delaware.

Timothy MORRIS

v.

GILLIS GILKERSON, INC. and Industrial
Accident Board,

No. 94A-09-006, 96A-10-005.

Nov. 25, 1997.

Edward C. Gill, Esquire, Law Office of Edward C.
Gill, P.A., Georgetown, Delaware.

Sean A. Dolan, Esquire, Tybout, Redfearn & Pell,
Wilmington, Delaware.

LEE, Resident J.

*1 Dear Messrs. Gill and Dolan:

Timothy Morris ("Claimant") files this appeal from the October 8, 1996 Opinion Upon Remand issued by the Industrial Accident Board ("Board"). Claimant originally appealed the Board's decision dated June 10, 1994, which denied Claimant's petition to determine compensation due for injuries allegedly suffered by Claimant on March 6, 1993 and on June 14, 1993, while employed by Gillis Gilkerson, Inc. ("Employer"). This Court remanded the Board's decision for reconsideration of certain issues. *See Morris v. Gillis Gilkerson, Inc.*, Del.Super., C.A. No. 94A-09-006, Lee, J. (Aug. 11, 1995). On remand, the Board reconsidered those issues and issued its October 8, 1996 decision. Claimant now appeals that decision to this Court. This is the Court's decision on that appeal.

FACTS

Claimant filed a petition to determine

compensation due on August 30, 1993, for an injury he allegedly suffered on March 6, 1993, while throwing debris off a roof on which he was working.^{FN1} In its June 10, 1994 decision, the Board denied Claimant's request for temporary total disability and medical expenses. It based this conclusion on Claimant's inability to persuade it that he suffered an injury from an industrial accident that occurred on March 6, 1993.

FN1. In that same petition, Claimant sought compensation for an injury allegedly suffered by him on June 14, 1993. This Court affirmed the Board's denial of this particular claim in its August 11, 1995 memorandum opinion. *Morris v. Gillis Gilkerson, Inc.*, *supra*, at 10-12.

After consideration of Claimant's appeal of that decision, this Court remanded the matter to the Board to reconsider two issues: (1) whether it relied on Ms. Johnson's testimony that the supervisor nicknamed "Elvis" did not report the incident to her on March 6, 1993 to deny Claimant's petition; and (2) whether evidence exists, other than Ms. Johnson's hearsay testimony^{FN2}, to support its denial of Claimant's petition to determine compensation due for the March 6, 1993 incident. *See Morris v. Gillis Gilkerson, Inc.*, *supra*.

FN2. The hearsay testimony in this case included statements made by Ms. Johnson, over Mr. Gill's objection, that "Elvis" did not report the March 6, 1993 incident to her on that day. *See* Transcript of Hearing, June 10, 1994, at 102-105.

The Board reconsidered these issues without further testimony or evidence. In its Opinion Upon Remand dated October 8, 1996, the Board reaffirmed its prior decision that Claimant failed to establish that he suffered an injury resulting from an industrial accident that allegedly occurred on March 6, 1993. First, it insisted that it did not rely

Not Reported in A.2d, 1997 WL 819110 (Del.Super.)
(Cite as: 1997 WL 819110 (Del.Super.))

upon the hearsay testimony of Ms. Johnson. Second, it stated that Claimant produced only his own testimony to show that he suffered an injury on that date. He introduced neither the testimony of a co-worker who allegedly witnessed the incident nor the supervisor nicknamed "Elvis" to whom he allegedly reported the incident. This lack of testimony stood in stark contrast, the Board noted, to the relative wealth of proof offered in connection with the June 14, 1993 incident.

Furthermore, while emphasizing again that it did not consider Ms. Johnson's hearsay testimony, the Board did take notice that while she did not have a record that the March 6, 1993 incident was reported to her on that day, she did have a record of the June 14, 1993 incident being reported to her on that date. Finally, the Board questions Claimant's credibility. The factors it considered in arriving at this conclusion were the inconsistent findings stated above and Claimant's failure to report taxable income received by him during 1991 and 1992.

*2 Claimant filed its appeal of this decision on October 25, 1996, alleging that the Board did not rely on substantial evidence and that it made errors of law.

DISCUSSION

Before I discuss the substantive issues on appeal, I first address one procedural matter. This matter, now on appeal to this Court for a second time, includes two separate civil action numbers. For the sake of efficiency, I hereby order the consolidation of these numbers, Civil Action No. 94A-09-006 and Civil Action No. 96A-10-005. Therefore, the parties shall file all future pleadings in this matter under Civil Action No. 96A-10-005, and the Court will issue an order regarding the captions in these matters contemporaneously with the issuance of this decision.

Turning now to the substantive issues, the Supreme Court and this Court repeatedly have emphasized the limited appellate review of the factual findings of an administrative agency. The

function of the reviewing Court is to determine whether substantial evidence supports the agency's decision. *Johnson v. Chrysler Corp.*, Del.Supr., 213 A.2d 64, 66-67 (1965); *General Motors v. Freeman*, Del.Supr., 164 A.2d 686, 688 (1960). Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Oceanport Ind. v. Wilmington Stevedores*, Del.Supr., 636 A.2d 892, 899 (1994); *Battista v. Chrysler Corp.*, Del.Super., 517 A.2d 295, 297 (1986), *app. disp.*, Del.Supr., 515 A.2d 397 (1986). The appellate court does not weigh the evidence, determine questions of credibility, or make its own factual findings. *Johnson v. Chrysler Corporation*, 213 A.2d at 66. It merely determines if the evidence is legally adequate to support the agency's factual findings. 29 *Del. C.* § 10142(d).

Claimant argues that the Board did not base its decision on substantial evidence.^{FN3} First, Claimant takes issue with the Board's reliance on the absence of testimony from the co-worker who witnessed the March 6 incident and from Elvis, since these employees were within Employer's control. Claimant believes that any favorable presumptions that the Board may have drawn from this absence should have been drawn in his favor and against Employer.

FN3. Employer responded to Claimant's arguments in a letter dated August 29, 1997, which stated that substantial evidence supports the Board's recent decision, and the Court should decide the matter based on the present record.

As this Court noted in its earlier decision, it is Claimant's burden, not Employer's, to establish that the alleged incident and injury occurred. *Morris v. Gillis Gilkerson, Inc.*, Del.Super., C.A. No. 94A-09-006, Lee, J. (Aug. 11, 1995) at 8, citing *Grays Hatchery & Poultry Farm v. Stevens*, Del.Super., 81 A.2d 322, 324 (1950). It is apparent from the record that Claimant testified that a co-worker witnessed the incident and that he reported the incident to Elvis. Knowing that Claimant had

Not Reported in A.2d, 1997 WL 819110 (Del.Super.)
 (Cite as: 1997 WL 819110 (Del.Super.))

the burden of proof in this case, the Board on remand reviewed the record and failed to find evidence supporting his claim. The absence of such evidence is a matter appropriate for Board consideration. *Glasgow Thriftway v. Donovan*, Del.Super., C.A. No. 90A-09-02, Gebelein, J. (Nov. 14, 1991) at 7, *aff'd*, Del.Supr., 610 A.2d 724 (June 22, 1992) (“[a]bsence of corroboration of claimant's testimony [is a] matter[] for the Board and the Court will not disturb its conclusion”). In addition, it matters not, as Claimant contends, that these witnesses were within Employer's control. As stated above, it was Claimant's burden to establish his claim. As such, it was his burden to produce the necessary witnesses to do so. Finally, Claimant offers no authority to support his claim that he deserves the benefit of favorable presumptions from possible testimony from witnesses that he should have produced to meet his burden of proof.

*3 Second, Claimant contends that the Board continues to rely on Ms. Johnson's testimony based on Elvis' hearsay statement as a basis for its finding that no accident occurred on March 6, 1993. Claimant further questions why the Board would admit such evidence in the face of objections from his counsel if it was not going to consider it.

As stated in its prior opinion, this Court recognized that “the question of whether appellant was injured in the course of his employment on March 6, 1993, was the primary question in this case.... [I]t was inappropriate to produce evidence that he did not report this injury to his supervisor, Elvis, through hearsay testimony.” *Morris v. Gillis Gilkerson, Inc.*, *supra* at 10. It is well-settled that the Board may hear hearsay testimony, *Singletary v. Townsends, Inc.*, Del.Super., C.A. No. 94A-09-005, Graves, J. (May 30, 1995) at 6, but it may not rely solely on such testimony for its determination. *Geegan v. Unemployment Compensation Comm'n*, Del.Super., 76 A.2d 116, 177 (Oct. 19, 1950) (emphasis added).

This Court finds that the Board's decision was not based solely on hearsay testimony. The Board

stated that it did not mention the hearsay testimony in its findings. *Cf. Dorsey v. Chrysler Motors Corp.*, Del.Super., C.A. No. 92A-09-021, Goldstein, J. (April 19, 1993) at 7 (Court concluded that Board's inclusion of summaries of officer's testimony in its summary of evidence was conclusive evidence that the Board believed such testimony to be part of the record that it considered in reaching its decision). Instead, it based its decision on Ms. Johnson's testimony that she did not have a March 6, 1993 record that Claimant was injured on that date, but she did have a June 14, 1993 record that Claimant was injured on that date. As a matter of fact, testimony regarding the absence of such a record for the March 6, 1996 incident was elicited by Claimant's counsel. (Tr. Bd. Hr'g at 116-117). The only record that she did have was the accident report that she filled out as she investigated the accident some days later. No hearsay objections were made during this portion of Ms. Johnson's testimony. Stating that she did not have a record of the March 6, 1993 incident being reported to her on that day was a fact known personally to Ms. Johnson and, in accordance with the rules of evidence, she could testify to it. D.R.E. 602.

The Court also finds no merit to Claimant's argument that the Board should not have allowed the evidence to be admitted if it were not going to consider it. To the contrary, “the mere fact that ... testimony included hearsay ... [does] not make it inadmissible, *per se*.” *White v. Greggo & Ferrara*, Del.Super., C.A. No. 93A-07-006, Silverman, J. (Feb. 14, 1994) at 9. The **only** limitation on the use of hearsay evidence of which this Court is aware is the Board's **sole reliance** upon such evidence. As stated above, this Court finds that the Board did not **rely solely** on hearsay testimony for its determination. Consequently, “mere admission of the hearsay evidence, whether proper or improper, does not warrant **reversal**.” *Crooks v. Draper Canning Co.*, Del.Supr., No. 196, 1993, Walsh, J. (ORDER) at 4 (citations omitted).

Not Reported in A.2d, 1997 WL 819110 (Del.Super.)
(Cite as: 1997 WL 819110 (Del.Super.))

*4 Finally, Claimant argues that it is much too late for the Board to question Claimant's credibility. It is well settled that issues of credibility are within the exclusive province of the Board. *Evans v. PEI Nanticoke Hospital*, Del.Super., C.A. No. 95A-02-002, Graves, J. (Aug. 7, 1995) at 3. Nevertheless, Claimant takes issue with the timing of its credibility determination. Yet he offers no authority to suggest that there is a time limit within which the Board must make this determination, especially in a situation where the Court remands the Board's decision. The Supreme Court has implicitly recognized this situation. *Lemmon v. Northwood Construction*, Del.Super., 690 A.2d 912, 914 (1996) (decision remanded to Board to make credibility determinations from the record). Here, the Board appropriately based its decision on the existing record without further testimony or evidence. *Davis v. Brandywine Raceway*, Del.Super., C.A. No. 91A-01-004, Balick, J. (Dec. 23, 1993) at 3 (Board may reconsider evidence previously presented in light of an appeal's court opinion); *Adams v. NKS Distributors*, Del.Super., C.A. No. 94A-11-011-RRC, Cooch, J. (ORDER) (Sept. 28, 1995) at 4, citing *Rock v. Shellhorn & Hill*, Del.Super., C.A. No. 94A-09-008, Silverman, J. (Dec. 12, 1994) (ORDER) at 2-3 ("[i]n its reconsideration of the entire record, the Board may rely on the prior proceeding insofar as it has a record of it"). Thus, this Court will not extend the parameters of its appellate review duties to reexamine questions of credibility. *Johnson v. Chrysler Corp.*, 213 A.2d at 66.

Based on the foregoing, the Board's decision on remand is hereby AFFIRMED.

IT IS SO ORDERED.

Del.Super.,1997.

Morris v. Gillis Gilkerson, Inc.

Not Reported in A.2d, 1997 WL 819110
(Del.Super.)

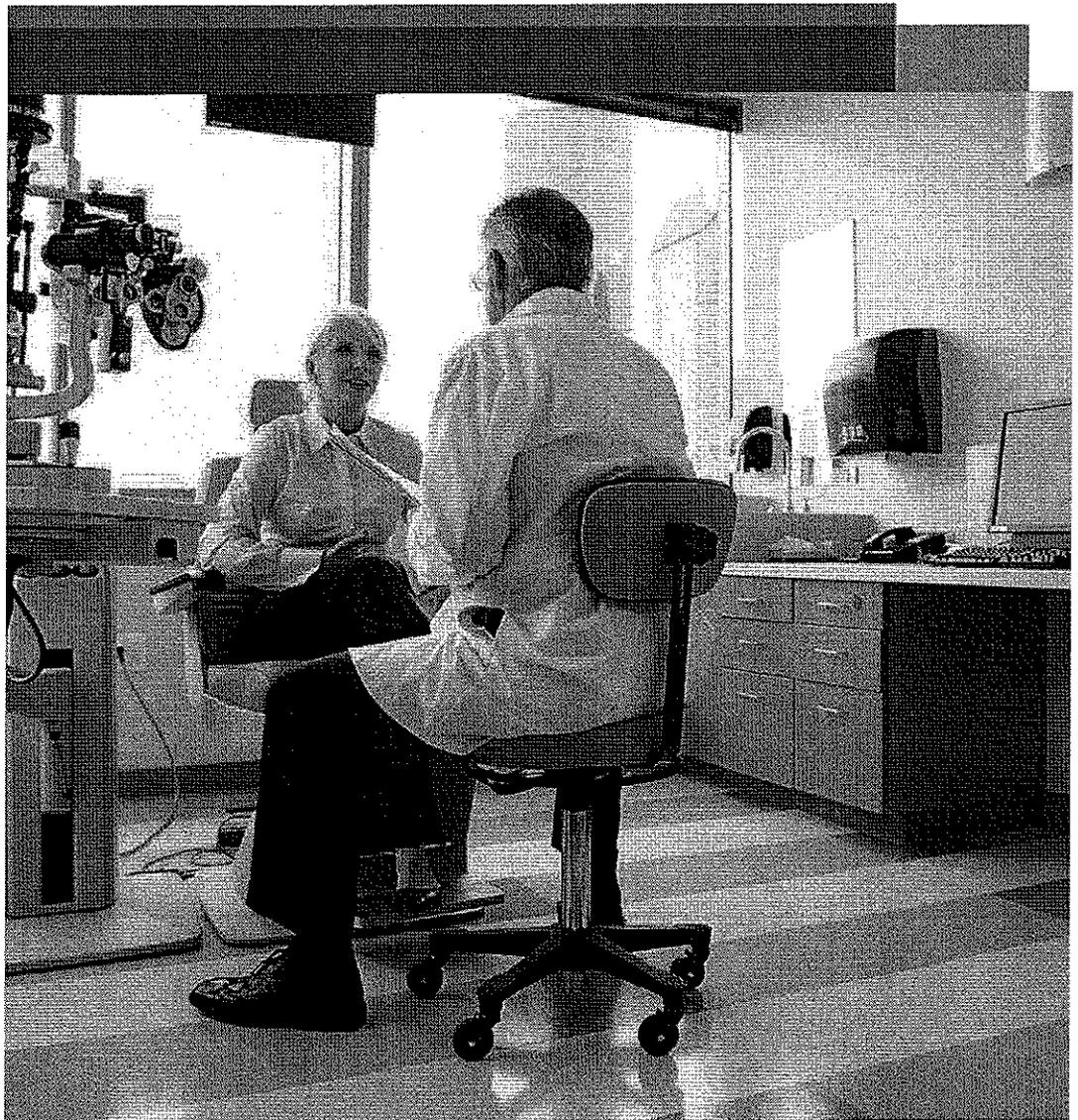
END OF DOCUMENT

ATTACHMENT K

Medical Cost Trend: Behind the Numbers 2014

June 2013

Health Research Institute



pwc

Table of contents

The heart of the matter 2

Defying historical patterns—and placing added tension on the health industry—medical cost trend in 2014 will dip even lower than in 2013. Aggressive and creative steps by employers, new venues and models for delivering care, and elements of the Affordable Care Act are expected to exert continued downward pressure on the health sector.

An in-depth discussion 4

For 2014, PwC's Health Research Institute (HRI) projects a medical cost trend of 6.5%. Taking into account likely adjustments to benefit design such as higher deductibles, HRI projects a net growth rate of 4.5%.

Executive summary	5
Medical cost trend in 2014	6
Factors affecting 2014 trend	7
Conclusion	15

What this means for your business 16

Employer engagement and individual consumers are powerful and growing forces in the health ecosystem. To succeed, healthcare organizations should fashion strategies around new demands for value.

Employers	17
Providers	18
Health insurers	19
Pharmaceutical and life sciences	20

The heart of the matter

Defying historical patterns—and placing added tension on the health industry—medical cost trend in 2014 will dip even lower than in 2013. Aggressive and creative steps by employers, new venues and models for delivering care, and elements of the Affordable Care Act (ACA) are expected to exert continued downward pressure on the health sector.

Medical cost trend measures spending growth in healthcare services and products—a key ingredient in setting the coming year's insurance premiums. For 2014, PwC's Health Research Institute (HRI) projects a medical cost trend of 6.5%. Taking into account likely adjustments to benefit design such as higher deductibles, HRI projects a net growth rate of 4.5%.

For an industry that until recently had consistently seen double-digit growth, the ongoing slowdown poses immediate financial challenges. At the same time, the imperative to do more with less has paved the way for a true transformation of the health ecosystem, from fee-for-service medicine to consumer-centered care that rewards quality outcomes.

Great uncertainty hangs over 2014, the watershed year for ACA implementation. Millions more Americans are expected to gain coverage through Medicaid or new online marketplaces. No one knows exactly who will enroll, what their medical needs will be, or how the industry will manage them. But none of these changes will likely directly affect the medical cost trend. Total spending will rise with the cost of caring for the newly insured, but the rate of growth, which is based on unit cost, should remain at some of the lowest levels since the government began measuring national health expenditures in 1960.

Even so, the headlines will be dominated by news of insurance premium increases, primarily in the individual market. The seeming contradiction between rising premium rates and slow spending growth can be explained by how the health system manages risk and uncertainty. When faced with covering a newly insured, largely unknown population, health plans sometimes increase premiums to guard against financial risks.

Industry executives, policymakers, and academics continue to debate whether the nation is finally reining in healthcare costs or just experiencing a temporary respite from skyrocketing growth rates. Historically, medical inflation jumps after the nation recovers from a recession. But changes in how the industry operates and how average consumers choose healthcare appear to be having a more sustained effect.

An in-depth discussion

For 2014, PwC's Health Research Institute (HRI) projects a medical cost trend of 6.5%. Taking into account likely adjustments to benefit design such as higher deductibles, HRI projects a net growth rate of 4.5%.

Executive summary

Healthcare organizations, hurt by a squeeze on reimbursements and what might best be described as a recession “hangover,” have spent the past few years adapting to more modest growth rates. The industry will continue those efforts in 2014, including pushing care to locations and personnel that cost less.

The tepid economic recovery continues to impact the health sector. The slowdown—and even decline—in personal wealth has tamped down demand for healthcare. As we reported a year ago, the sluggish recovery has created a “new normal” in healthcare spending patterns.

Individual consumers, bearing more financial responsibility for their medical bills, are questioning and sometimes delaying procedures, imaging, and elective services. New delivery models, such as accountable care organizations (ACOs) are promising, but their prospects for significant savings remain largely unproven.

The ACA will also play a role in the slowdown in 2014, with hospitals working to hold down expensive readmissions (or face the law’s penalties) and employers being given greater power to influence employee behavior through increased or discounted premiums—up to 50% in some cases.

Each year, HRI issues its projection for the following year’s medical cost trend based on activity in the market that

serves employer-based insurance. For its 2014 projection, HRI interviewed industry executives, health policy experts and health plan actuaries, whose companies cover a combined 95 million members. In this year’s report, we identified:

Four factors deflate medical cost trend in 2014

- Care continues to move outside costly settings such as hospitals to more affordable retail clinics and mobile health. Consumers value the convenience, and costs can be as little as one-third of the bill in a traditional healthcare site.
- Major employers such as Walmart, Boeing, and Lowe’s now contract directly with big-name health systems for costly, complicated procedures such as heart surgery and spinal fusion. The employers are making the move to “high-performance networks” far away from the home office in the belief that even with travel costs, these networks still deliver overall savings.
- The federal government’s new readmission penalties take direct aim at waste in the health system, estimated to be as high as 30%. According to government data, hospital readmissions dropped by nearly 70,000 in 2012, and this trend is expected to accelerate through 2014 as hospitals focus on discharge planning, compliance and the continuum of care.¹

- Seventeen percent of employers in PwC’s 2013 Touchstone Survey today offer a high deductible health plan as the only option for employees. And more than 44% are considering offering it as the only option. When consumers pay more for their healthcare, they often make more cost-conscious choices.

Two factors inflate medical cost trend in 2014

- Until recently, widespread adoption of generic medicines helped dampen overall medical inflation, but the rise of expensive complex biologics will nudge spending trends upward. Approvals of new biologics now outpace traditional therapies, and that pattern will continue in 2014 as research efforts target complex cases such as cancer.
- Health industry consolidation has increased more than 50% since 2009—activity that is expected to continue through 2014.² Higher prices are sure to follow in some markets. According to a recent report, hospital mergers can lead to price increases of up to 20%.³ These price increases are especially acute in markets with one dominant system.

What this means for your business

Employer engagement and individual consumers are powerful and growing forces in the health ecosystem. To succeed, healthcare organizations should fashion strategies around new demands for value.

Medical cost trend in 2014

PwC's Health Research Institute (HRI) projects that 2014 medical cost trend will be 6.5%—a full percentage point lower than our estimate of 7.5% for 2013.⁴ This projection is based on data analysis of medical costs in the large employer market, which covers about 150 million Americans.

The net growth rate, after accounting for benefit design changes such as higher deductibles, will be about 4.5%. In recent years, adjustments to employer benefit plans have helped to reduce benefit cost increases by 1.5 to 2 percentage points by shifting some expenses onto workers and implementing incentives for employees to be more cost-conscious consumers.

The historically low medical cost trend for 2014 did not occur overnight. Utilization of many medical services

slowed over the past decade, as consumers made fewer visits to the doctor's office, postponed procedures, cut back on medications, and reconsidered imaging and elective surgeries. First quarter results for publicly-traded hospitals in 2013 reported a decline in demand for services.⁵

PwC's 2013 Touchstone Survey of large US employers confirms that businesses are increasing cost sharing and plan to continue using that strategy to moderate spending growth. Between 2009 and 2013, emergency room copayments were up 50%, while prescription drug copayments for specialty drugs increased 94%. The average deductible for in-network services is now more than \$1,000, and out-of-network services is more than \$2,000 (see Figure 1).

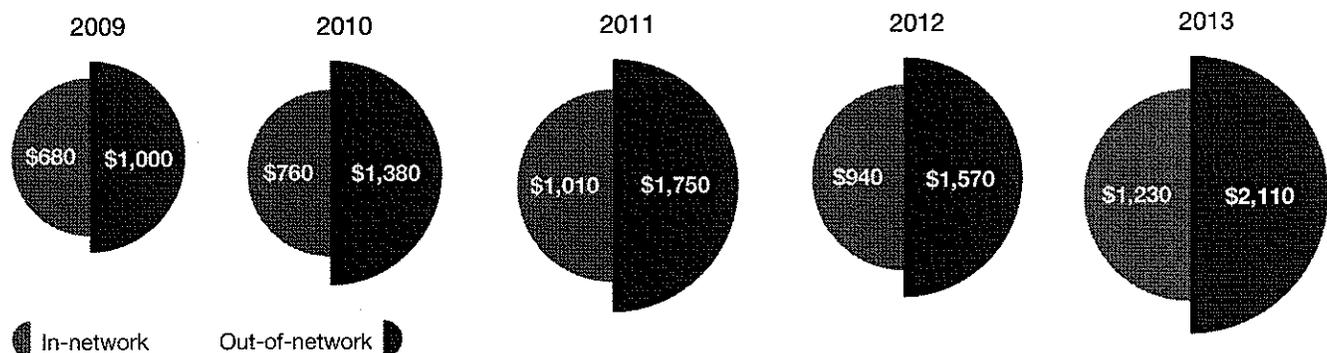
What is medical cost trend?

Medical cost trend could be defined in several ways; for this report, medical cost trend is the projected increase in costs of medical services assumed in setting health insurance premiums for commercial insurers and large, self-insured businesses. Medical cost trend is the projected percentage increase in the cost to treat patients, or the healthcare spending growth rate. The projection is used by insurance companies to calculate health plan premiums for the coming year. For example, a 10% trend means that a plan that costs \$10,000 per employee this year would cost \$11,000 the following year. The cost trend, or growth rate, is influenced primarily by:

- Changes in the price of medical products and services, known as unit cost inflation
- Changes in the number of services used, or per capita utilization increases

Figure 1. Average deductibles for in and out-of-network visits are increasing*

In-network and out-of-network deductibles



Source: PwC 2013 Health and Well-Being Touchstone Survey

* Calculations are based on employee health plans with a deductible

Factors affecting 2014 trend

New care venues, high-performance networks, lower hospital readmissions, and high deductible plans deflate cost trends

Convenient care is cost-efficient care

Healthcare will continue to move out of hospital and physician offices in 2014. More care will be delivered via the Internet and in locations such as retail centers, a trend fuelled by the rise of cost sharing, the arrival of millions of newly insured patients, and a growing demand for convenience. The new care venues are not only consumer-friendly, but also less expensive. Gaining in popularity, these will slow the rise in medical costs next year.

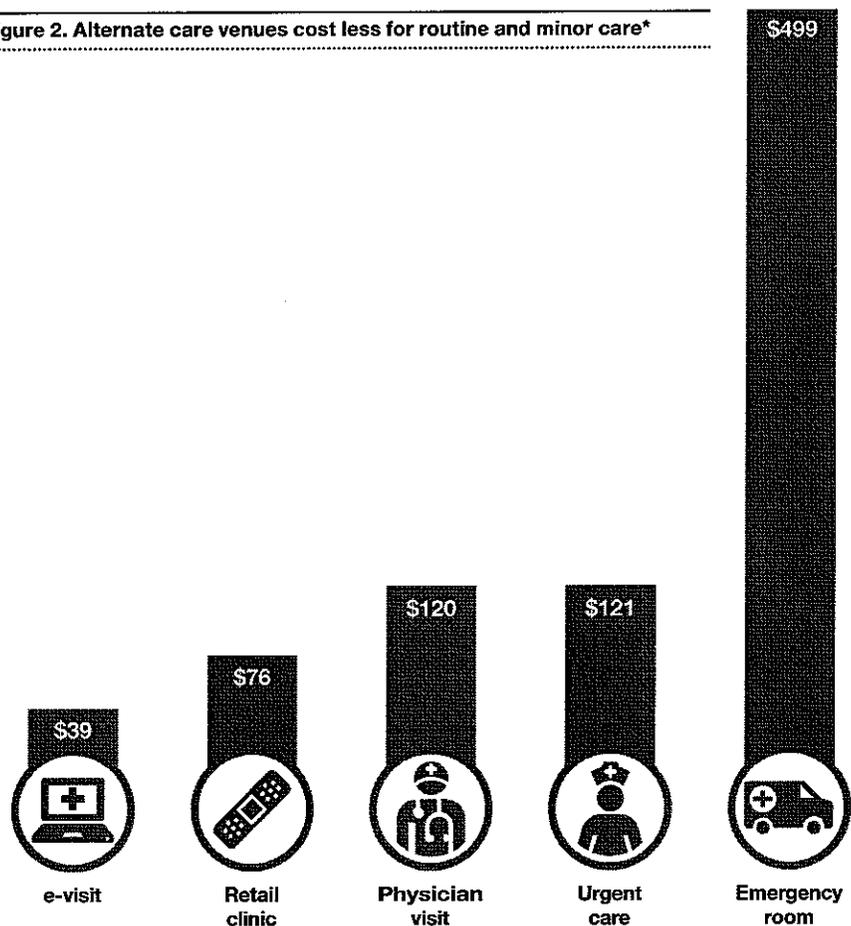
Consumer use of retail clinics nearly tripled over the last five years, according to an HRI survey of more than 1,000 consumers conducted in late 2012. In 2007, 9.7% of consumers had visited a clinic; in 2012, 24% had. Virtual visits also can be consumer-friendly and lower-priced. One industry analysis projects telemedicine visits will grow 55% in 2013.⁶

HRI's analysis of cost of care for simple conditions such as sinusitis or colds shows that these visits in emergency rooms cost almost seven times more than retail clinics and 13 times more than e-visits (see Figure 2).⁸ In one calculation of potential savings, HealthPartners, a non-profit insurer based in Minnesota, reported an average savings of \$88 per episode in online clinics versus traditional clinics. Customer satisfaction was also high.⁷

As consumers seek more convenient care, businesses such as Walgreens are responding by offering more sophisticated services, such as chronic health management, in their retail clinics. The clinics will assess a person's chronic condition and guide treatment and management of the illness. With more than half of the nation's population expected to have at least one chronic condition by 2020, the market potential is phenomenal.⁹ Chronic illnesses represent 75% of healthcare spending today.¹⁰

Mary Grealy, president of the Healthcare Leadership Council, a Washington, DC-based membership organization for health executives, is "seeing more members pushing full speed ahead to offer more healthcare services in retail clinics and on-site employer clinics to keep employees out of the emergency room and lower costs."

Figure 2. Alternate care venues cost less for routine and minor care*



Source: PwC Health Research Institute

* Minor illnesses include sinusitis, urinary tract infections, common cold, or flu.

High performance- networks deliver more

Faced with high medical bills, employers are combing the country for doctors and hospitals that can provide high-quality care at a lower price. These newly-formed groups of providers, known as high-performance networks, often specialize in high-cost or high-risk procedures such as heart surgery or transplants. The use of high-performance networks is still in its infancy, but early data suggest the savings range from 10–25% off the total cost.¹¹

With money and employee productivity at stake, employers have started to contract directly with providers. This is especially true of large employers that are self-insured and bear the financial risk for their workers' health costs (see Figure 3). For example, Lowe's has chosen Cleveland Clinic for heart surgery. The care is provided for a flat fee, and Lowe's covers all travel expenses.

"We have had good success with the program. The outcomes are good, service is world class, and 98% of those who have used the program are very satisfied," said Randy Moon, vice president of international human resources and benefits at Lowe's. "Costs per episode have been cheaper because of the bundled payment model and Cleveland Clinic's coverage of any follow up treatment. We are now considering offering similar programs for other health situations at Cleveland, as well as utilizing centers of excellence that are more regionally-based."

These "centers of excellence" have such strong quality scores and competitive pricing that the cost of travel is easily recouped, proponents say. Expect to see more large employers embark on this path, helping slow medical inflation.

"Large employers are the vanguard, and they see the value in high quality at a lower cost. That's why a few of the larger companies are pursuing these

Adding confusion to a complicated year, premiums may rise in the individual market

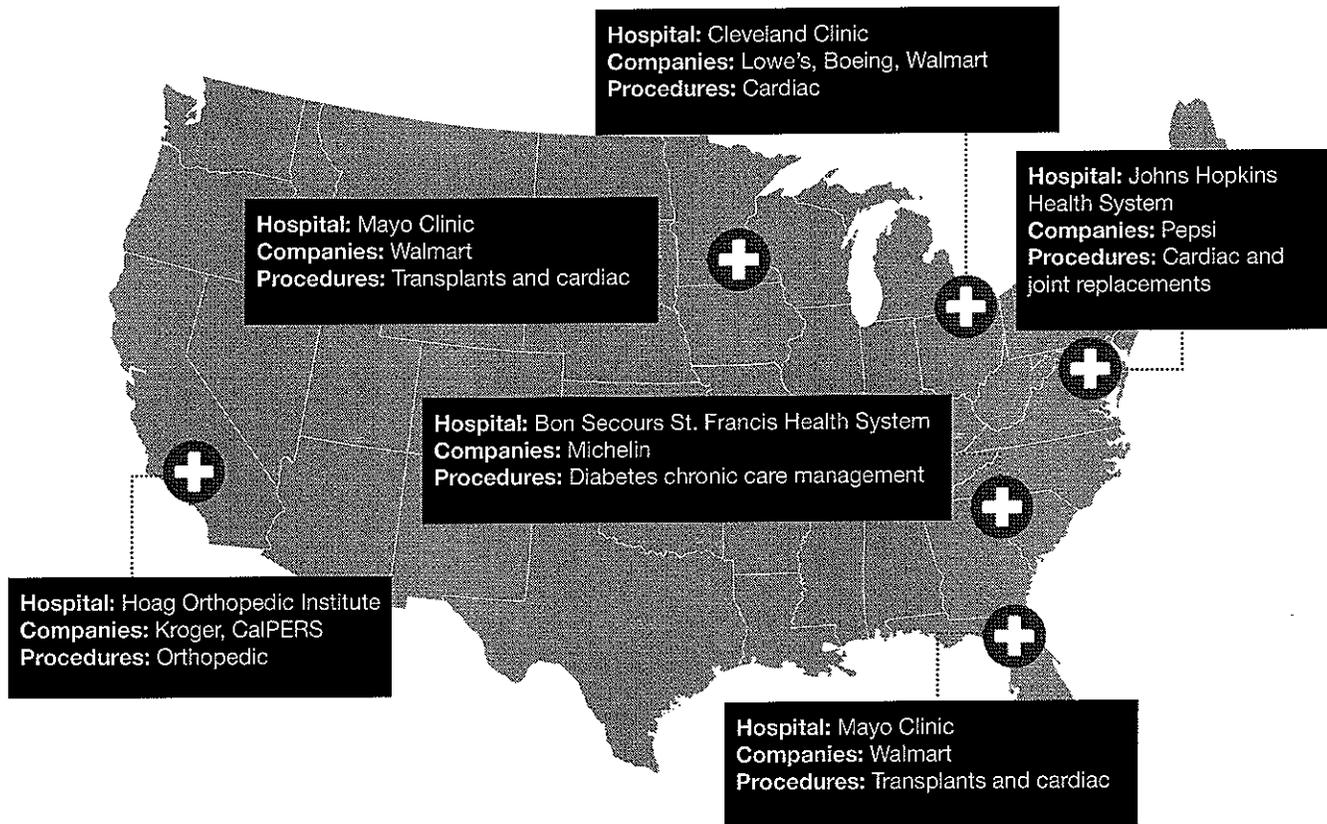
The scope of this research is limited to trends in the large employer market. However, premium costs will generate headlines and likely confuse the public with seemingly contrary signals. A decrease in the overall growth rate does not mean automatic decreases in premiums, particularly those in the individual market. Premium increases tend to be highly variable and depend on many factors such as region, age, and types of plans. When setting premiums, insurers must try to forecast the risk profile of the members—and their medical needs.

In 2014, there will be a new force pushing apart premiums and medical cost trend—the ACA. The law requires virtually every American to have health insurance coverage. Many of the newly insured will participate in new online marketplaces known as exchanges. Insurers face the uncertainty of who will enroll—the sick, the healthy or a combination of the two. A plan dominated by severely ill patients could wipe out reserves; healthier members would help spread the financial risk.

"When there is uncertainty, along comes conservatism," Mark D. Birdwhistell, vice president, administration and external affairs for the UK HealthCare in Lexington, Kentucky, said in an interview. "Health plans will have to accommodate for that uncertainty through increases in premiums to ensure they have all bases covered."

Figure 3. Large employers partner with providers for specialized services

Large employers such as Lowe's and Walmart are partnering directly with hospitals to provide services. Many of these are bundled payments for procedures such as heart surgeries or knee replacements. Some employers pay all related travel costs as well as waive deductibles.



Source: PwC Health Research Institute^{12,13,14,15,16,17,18}

specialized networks directly with health systems,” said Helen Darling, president and CEO of the National Business Group on Health.

In 2012, grocery chain Kroger, signed an agreement with Hoag Orthopedic Institute in Irvine, California and several other hospitals for hip, knee, and spinal fusion surgeries. Employees pay 10 % out of pocket if they choose one of the 19 selected hospitals, compared to 25 % to 50 % for centers not on the list.¹⁹ In 2012, 8% of Kroger employees chose the high-performing

hospitals for surgery, exceeding its goal of 6% utilization. Total costs were 25.5% less for surgeries, and patients using the facilities had no reported readmissions.²⁰

The UK HealthCare has built a “virtual high-performance network” in which specialists travel to rural clinics to deliver care for complex cases such as cancer and transplants. “The approach reduces duplication of tests and standardizes treatment, two major cost savers,” said Birdwhistell.

Readmissions ratchet down

According to the Centers for Medicare and Medicaid Services (CMS), 30-day hospital readmissions for Medicare beneficiaries had been stuck at about 19% for years when the ACA imposed penalties for high readmissions in late 2012. Almost immediately, the rate fell to an average of 18.4%. Even so, more than 2,200 hospitals (two-thirds of US facilities) will face penalties for unacceptably high rates in 2013.²²

With the penalties set to increase and the public focusing on patient safety, hospitals will act aggressively in 2014 to ensure patients don't require a return trip (see Figure 4). As this activity spreads, it will push down medical cost trend.

Reducing hospital readmissions not only improves care, but it also significantly reduces the cost of

treating hospital-related problems such as infections, falls, and poorly managed follow-up. The cost of readmissions for Medicare patients alone is \$26 billion annually.²³

The ACA encourages hospitals to get treatment right the first time. The estimated savings from better care is \$630 million in 2014, increasing to more than \$1 billion in 2015.²⁴

Some analysts caution that hospitals can record a decline in readmissions if more care is billed as "observational," but many healthcare executives say they are focused on true improvements to care. According to a recent survey, 69% of hospitals had a readmissions reduction program in place. Eighty percent of the hospitals without a program reported that they plan to launch one this year.²⁵

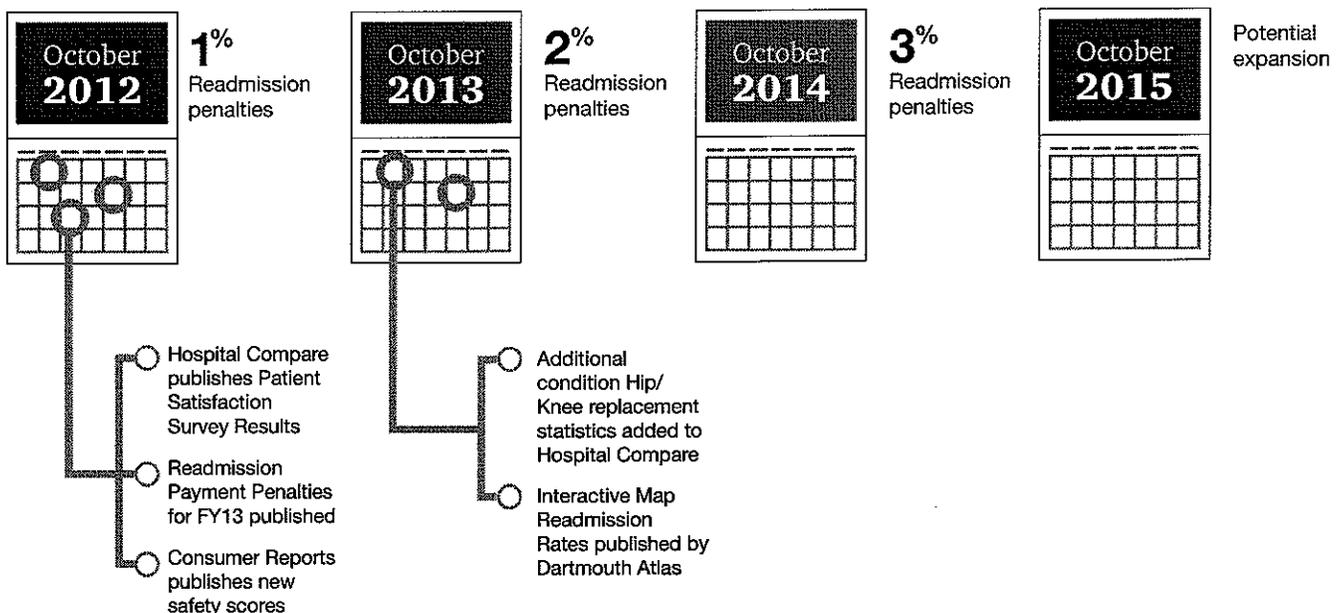
This response is not just about avoiding penalties. An increase in media coverage of readmissions shows the topic is capturing the public's attention and may amplify financial penalties through reputational risk.

Hospitals are not alone in the push to reduce costly readmissions. Insurance giant Cigna, for example, provides hospitals with data to identify patients at risk for readmission. Early identification means doctors and nurses can pay special attention to the risk factors most likely to trigger a return to the hospital.

Many healthcare systems are also creating plans for better follow-up after discharge. Some are even partnering with skilled nursing facilities and home health services.

Figure 4. Hospital readmission penalties increase along with publicly reported results

Hospital readmissions timeline and highlights of consumer ratings



Source: PwC Health Research Institute^{26,27,28,29,30}

High-deductible going mainstream

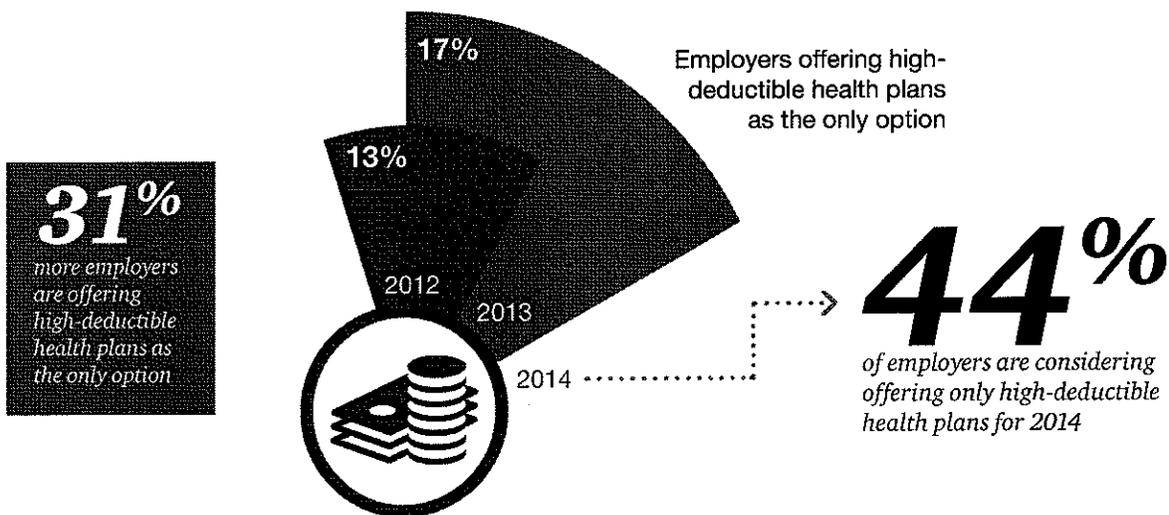
Consumer-driven health plans—insurance coverage with a high-deductible—are set to go mainstream in 2014. According to the 2013 PwC Touchstone Survey of major US companies, 44% of employers are considering offering high-deductible health plans as the only benefit option to their employees in 2014. Already, 17% of employers offer high-deductible plans as their only option in 2013, a 31% increase over 2012 (see Figure 5).

While medical cost trend does not take into account specific changes in benefit structure, shifts in design ultimately influence consumer behavior, which in turn impacts medical spending and cost patterns. High-deductible health plans, which place greater responsibility on consumers, are designed to promote cost-conscious decisions. A recent study reported families that switched

from a traditional health plan to a high-deductible plan spent an average of 21% less on healthcare in the first year.³¹ If 50% of workers with employer-sponsored programs chose high-deductible plans, healthcare spending could be reduced by about \$57 billion, or a 4% decline in total healthcare costs, according to a study in the journal *Health Affairs*.³²

The ACA, with its new insurance marketplaces, accelerates the move to consumer-driven plans. In 2014, an estimated 12 million consumers will choose a health plan in the new insurance exchanges.³³ HRI demographic analysis and consumer interviews indicate this will be a price-sensitive customer group. Many of the newly insured say they are willing to accept plan features such as higher deductibles in return for lower monthly premiums—as found in the new bronze and silver plans.

Figure 5. High-deductible health plans are becoming more prevalent for employers



Source: PwC 2013 Health and Well-Being Touchstone Survey

Specialty drug costs cancel out generic drug savings

The growth rate in drug spending has been declining for years due to the widespread adoption of generic medications. But that is about to change. First-time generic approvals peaked in 2012 with generic versions of medications such as Plavix, Singulair, and Lexapro.³⁴

Although generic drug use will remain high, there will be fewer new ones entering the market. And there will be a major counterweight to the spending trajectory—an increase in the use of complex, expensive specialty drugs.³⁵

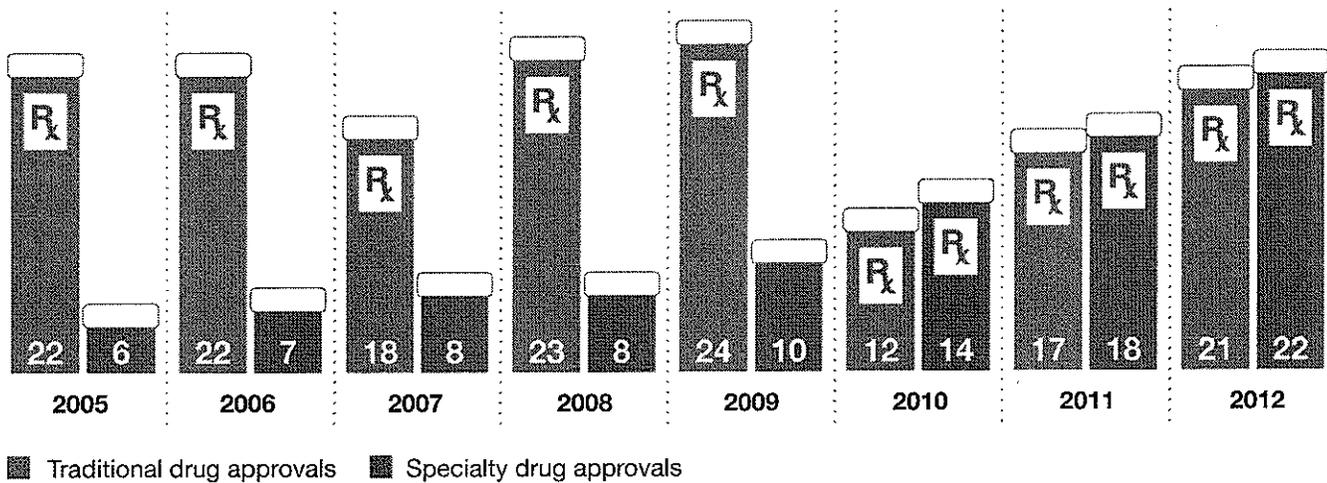
Greater understanding of the molecular and genetic basis of disease has promoted development of sophisticated new medications for chronic illnesses such as multiple sclerosis, rheumatoid arthritis, and cancer. In 2005, 21% of new drug approvals by the U.S. Food and Drug Administration (FDA) were for specialty medications. By 2012, these therapies accounted for over half of approvals (see Figure 6). The pace is expected to quicken in 2014, with specialty drugs poised to account for up to 60% of new approvals and seven of the top 10 best-selling therapies.³⁶

The numbers illustrate why prescription spending is poised to nudge medical cost trend up. Specialty drugs—biologics made from living organisms—are more complex than many traditional therapies and have a much higher average cost. Spending on specialty drugs increased 18% in 2012 and is expected to rise by 22% in 2014.³⁷ The drugs are projected to hit 45% of US prescription sales volume by 2017.³⁸

Figure 6. FDA approvals of specialty drugs rising rapidly

Specialty drug costs cancel out generic drug savings

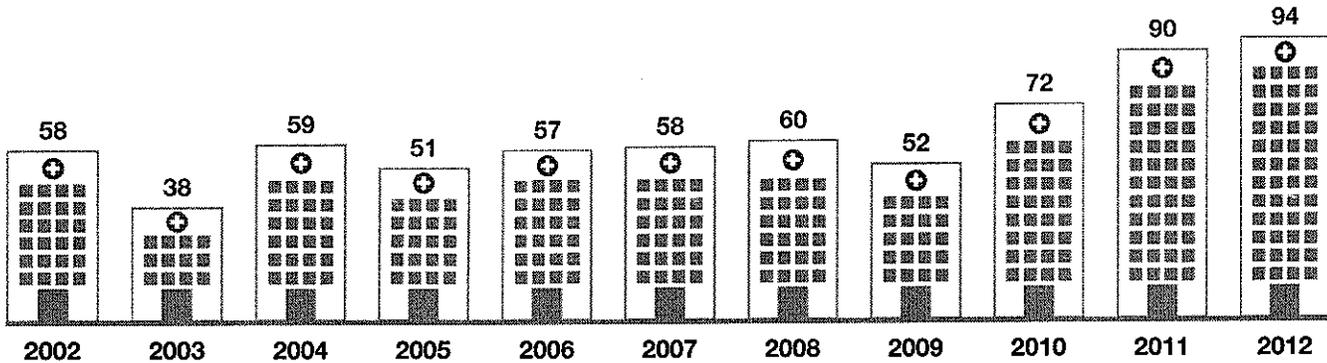
2010 was the first year specialty drug FDA approvals were higher than traditional drug approvals. This trend is expected to continue into 2014, with specialty drugs poised to account for up to 60% of new approvals.



Source: FDA, PwC Health Research Institute

Figure 7. Hospital deals on the rise

Industry consolidation can lead to higher prices



Source: Irving Levin Associates

Industry consolidation can lead to higher prices

Hospital merger and acquisition activity has increased nearly 50 % since 2009, reaching its highest point in the last 10 years—even surpassing the number of deals seen at the height of the 1990’s merger craze (see Figure 7). The activity shows no sign of abating in 2014. Over half of hospitals plan to acquire physician practices in 2014, compared to 44% in 2012, according to one industry survey.³⁹ And the data understate the volume of activity happening through affiliations and joint ventures.

With consolidation, higher prices often follow. Studies have shown that hospital mergers in concentrated markets can increase prices by more than 20%.⁴⁰ Insurance companies contract with hospitals for services, and they are often the first to experience price changes.

Despite the economies of scale that consolidation offers, many insurance companies report an immediate increase in hospital rates. Often the new entity adopts the higher payment rates of the two. Some smaller, independent hospitals have used the mere specter of consolidation with a larger hospital to negotiate better payment.

Physician employment can also increase prices. When physician groups join a hospital system, a “facility fee” is typically added for procedures performed in a hospital or surgery center. The result—overall costs are greater than if the same procedure were conducted in the physician’s office.

Higher prices associated with hospital consolidation can trigger increased government action. In Massachusetts, one-third of hospitals have merged, acquired, or partnered with another

system in the past three years, and prices have remained among the highest in the nation.⁴¹ In response, the legislature has enacted laws that peg health spending to economic growth and increased price transparency.

The promise of provider consolidation is that it can improve efficiency by both eliminating duplication and by delivering integrated care supported by a larger organization with more resources. But it also can lead to increased market power and higher prices. “They aren’t taking the waste out of these systems fast enough,” Darling, of the National Business Group on Health, told HRI.

Early hints of promise from accountable care organizations

Some ideas need time to mature. Accountable care organizations (ACOs) have big ambitions—to lift quality, hold down costs, and create happy customers. Hopes are high that these new groups can curb healthcare spending too, though it may be years until the evidence is in. Although some say they resemble HMOs from the 1980's, they are different because they are physician- and hospital-led.

Hundreds of hospitals, physician groups, and insurers are assembling into ACOs, trying to capture savings generated by better—and better-coordinated—care. Providers such as Baylor Health Care System and Advocate Health Care are developing their own ACOs, as are insurers such as Highmark and Aetna. Cigna has committed to forming 100 ACOs by the end of 2014.

The Centers for Medicare and Medicaid Services (CMS) has approved more than 250 Medicare ACOs, serving more than 4 million beneficiaries. During a U.S. Senate Finance Committee hearing this spring, CMS chief Marilyn Tavenner called the programs “one of the Affordable Care Act’s key reforms to improve delivery of care.”

Early data from a federal pilot program of Medicare patients point to modest savings. The pilot, formally known as the Physician Group Practice Demonstration, saved \$137 million over five years across 10 participating physician groups, an average of \$114 per year per beneficiary.⁴² Similarly, in 2009 spending grew about 2% less per quarter for enrollees in Blue Cross Blue Shield of Massachusetts’ ACO-like program compared to its traditional programs.⁴³ Blue Cross Blue Shield reported that 2010 savings were even higher.

Cigna believes its ACOs can bring costs down and is aiming for 1 million members in its ACOs by the end of 2014. “Our per patient annual cost growth is 50% lower for members in our ACO than members covered by traditional fee-for-service,” said Cigna Healthcare national medical officer Dr. Ozzie Khan.

Emergency room visits fell 7% across the system, while quality indicators for procedures such as mammograms and cervical cancer screenings are up about 5%, Khan said. To achieve these results Cigna encourages primary care physicians to refer patients to specialists with proven quality. Khan adds that, “we share specialist quality data with our ACO physicians so they can make an informed decision about who they send their patients to.”

Yet some healthcare executives interviewed by HRI remain skeptical and stressed that savings from ACOs will likely take a few years before influencing overall U.S. health spending. Some said that ACOs may even push costs higher in the beginning as systems invest in infrastructure and technology such as electronic medical records. “There are promising signs of cost savings, but it’s still a little too early to tell how extensive and sustainable they are,” said Mary Grealy, president of the Healthcare Leadership Council.

Conclusion

In short, 2014 will be one of the most complex years the health sector has faced as it takes on major uncertainty in an environment of constrained resources.

The numbers are encouraging. Medical inflation has slowed—from an unsustainable 11% in 1990 to 3.9% in 2011, according to the most recent government data available.⁴⁴ Annual Medicare spending rose just 1.7% per beneficiary from 2010 to 2012, compared to 6% per year in the previous two decades. The slower trend has been welcome news for healthcare purchasers and federal budget writers, but poses difficulties for healthcare organizations.

Initially, the slowdown was attributed primarily to cuts in payments to doctors, hospitals, and drug makers. Over time, however, the industry has begun to refashion itself, and for the second year in a row, HRI's annual report on medical cost trend identifies structural changes that are altering how and where care is provided. In the case of some changes, such as accountable care organizations,

it is still too early to know whether the savings will be significant and long term.

Employers and consumers are also impacting medical cost trend as they comparison shop for healthcare—whether it is a business sending complex cases to a “center of excellence” hundreds of miles away or a family enrolling in a wellness program to reduce its insurance premiums.

Millions of new customers are on the way because of coverage expansions in the ACA. Much will depend on the health risk profile of the newly insured and how the industry manages them. HRI demographic analysis projects the group as a whole is relatively young (median age 33).⁴⁵ On average, these potential new customers also consider themselves to be in good health, are less educated, poorer, and may not speak English as its first language. Few have navigated the formal health system, presenting challenges around education, outreach, and enrollment.

It appears the cost curve is starting to bend—now the question is whether the health industry can continue on the path to full transformation.

What this means for your business

Employer engagement and individual consumers are powerful and growing forces in the health ecosystem. To succeed, healthcare organizations should fashion strategies around new demands for value.

Employers

What are they doing now?

Employers remain concerned about their long-term ability to provide comprehensive health benefits. Despite a slowdown in medical inflation, costs continue to rise faster than GDP. In answer to the rising costs, businesses continue to shift more of the financial burden onto workers, are reducing retiree benefits and pursuing more aggressive strategies to promote measurable health outcomes.

Employers still describe health insurance as a valuable tool for recruitment and retention, and tax advantages are expected to keep employer coverage at high levels in 2014. In Massachusetts, employer-sponsored coverage has risen since the state enacted its healthcare overhaul seven years ago, even as employer coverage declined nationally.⁴⁶

Employers are self-insuring more than ever before. Over 80% of large employers and a third of small employers are providing their own coverage. The ACA exempts self-insured employers from a new industry tax on commercial insurance plans.⁴⁷ Some employers are evaluating a move to private insurance exchanges, in which employees choose from a range of benefits packages. Other employers are considering paying a penalty in lieu of providing coverage.

Things to consider

- *Explore high-performance networks even if they are not local.* Employee travel expenses may be well worth the cost if employees have better outcomes at lower prices. Employers should find health plans that offer a high-performance network for medical care or contract directly with these health systems.
- *Encourage use of new care venues.* Onsite work clinics, retail clinics, and mobile health options are convenient and typically less expensive than traditionally delivered care. Round-the-clock care centers reduce time spent away from work.
- *Educate employees and families about their options and responsibilities.* As high-deductible plans become more of the norm, employers should ensure that employees understand their benefits and responsibilities. Studies have shown that some people in high-deductible plans forgo preventive care that is fully covered by the plan.⁴⁸ “Health navigator” programs that guide employee decision-making can be a worthwhile investment for businesses.
- *Embrace the data.* Employers need to evaluate program results to determine what works and then continuously modify strategies to improve the value of the programs they offer and the care that their employees receive.

Providers

What are they doing now?

Reducing costs has been the focus for hospitals for the past few years. Many have addressed simple reductions in labor force and supply chain management. Now other factors are coming into play. As the federal government continues to shrink reimbursement, hospitals and doctors are focused on full-scale transformation that shifts incentives away from fee-for-service medicine toward outcomes-based payment. Additionally, hospitals have been forming partnerships with urgent care centers and retail clinics that offer less expensive and more convenient options and that also expand their referral network for complex cases.

Things to consider

- *Apply predictive analytics to target high-cost patients.* After years of preparing to meet the government's "meaningful use" requirements, hospitals can now use EHR data to target high-risk/high-cost patients. Health information technology will be critical to achieve care integration and to reduce costs associated with redundant testing and delays in follow-up care.
- *Forge new alliances.* As accountable care and readmission penalties become the norm, hospitals should partner with long-term and home care to ensure sustainable results. Hospitals may also need to build on their current information technology capabilities by partnering with insurers to access data beyond their systems.
- *Invest in the human side of HIT.* Hospitals should not only continue to focus on building their technology infrastructure, they should also develop the resources necessary to implement and run these systems. Two-thirds of healthcare providers are experiencing IT staff shortages, according to HRI research.⁴⁹
- *Align individual incentives with organizational incentives.* As organizations switch to different payment models, clinicians and staff need incentives such as performance metrics that link compensation to quality.

Health insurers

What are they doing now?

Preparing for the uncertainty of 2014 has been a major challenge for insurers. The health insurance business model is fundamentally shifting from a wholesale approach primarily focused on group insurance to a retail approach focused on serving the growing individual market. New rules related to the ACA have prompted insurers to develop plans to meet the requirements for operating in health insurance exchanges, which will serve the 27 million individuals expected to gain coverage over the next decade.

Health insurers face intense scrutiny regarding premiums. The ACA requires a review of rate hikes of 10% or more by state insurance commissioners or the U.S. Department of Health and Human Services. Insurers are struggling with how to price new products when the risk profile of the newly insured is largely unknown. Early premium pricing in state exchanges has already prompted some payers to lower their prices under the spotlight of transparency.

Things to consider

- *Form strong partnerships with providers.* As health insurers shift to payment models rewarding quality and efficiency, they should work closely with providers to hit ambitious new targets. Insurers should share data that helps hospitals and physicians manage the highest cost population segment with multiple chronic conditions.
- *Empower consumers to make cost-efficient choices.* Team up with employers to give employees information on lower-cost options. Encourage the transparency of quality measures, and provide information comparing different treatment options.
- *Focus on high-cost specialty drugs.* A top concern of government and private purchasers is the growing use of expensive specialty drugs. Insurers can help push for data to manage this growing cost.
- *Provide access to high-performance networks.* Offer companies new solutions to bend the cost curve. Identify and promote high-performing hospitals for complicated and costly procedures. Help companies understand that poor quality compounds the total cost of treatment.

Pharmaceutical and life sciences

What are they doing now?

Pharmaceutical and life sciences companies have been realigning business strategies to address the new environment of constrained growth. One recent HRI survey found that 35% of life sciences companies have revamped their R&D models in the past three years. Those models are now focused more on partnerships, alliances, and even outsourcing.⁵⁰ The need to demonstrate cost-effectiveness has prompted companies to invest in clinical informatics and health economics analytics teams.

Biologics have become an increasing focus for many drug makers. They offer long term market protection from generic competition as high start-up costs are a barrier to market entry for biosimilar manufacturers. However, pressure to address the rising costs of specialty drugs is a top priority for employers and insurers, and may create challenges to the growth and profitability of these drugs. Pharmaceutical companies are addressing cost pressures by investing in companion diagnostics that use evaluation tools to ensure these expensive drugs are targeted at the right patients.

Things to consider

- *Get closer to insurers and providers.* Collaborative relationships that demonstrate effective outcomes enable drug makers to address challenges early in the development process and adapt drug design and payment methods to make them attractive to purchasers.
- *Follow pharmacy benefit decisions.* Which drugs are covered will vary significantly from state to state and plan to plan. Drug makers will need to assess how the pharmacy benefit differs in each exchange and develop an appropriate strategy to get their products covered.
- *Evaluate data and apply to R&D processes.* The push for cost-effective medications continues. Drug makers must continually demonstrate the value of their products with compelling cost and quality studies.
- *Understand how companion diagnostics affect drug treatment decisions.* Companion diagnostics offer the promise of targeted therapies and reduced spending on treatments that may not be effective for certain individuals. Insurance companies hope to use companion diagnostics to shrink total costs through more effective treatment.

Notes

- 1 Good news on innovation and healthcare, White House Blog, Secretary Kathleen Sebelius, May 28, 2013, <http://www.whitehouse.gov/blog/2013/05/28/good-news-innovation-and-health-care>.
- 2 Irving Levin Associates.
- 3 Robert Wood Johnson Foundation, "The impact of hospital consolidation—Update", June 2012.
- 4 All numbers are national estimates. Cost trends may vary from market to market depending on the level of provider and health plan competition as well as the regional economy. In addition these numbers will vary by employer based on the benefit plan design and impact of their specific health and productivity efforts.
- 5 Kutscher B. "Feeling the outpatient pinch." *Modern Healthcare*. 27 April 2013.
- 6 IMS InMedica study: Telehealth—An Analysis of Demand Dynamics—2012 Edition.
- 7 Courneya PT, Palattao KJ, Gallagher JM, "HealthPartners' Online Clinic For Simple Conditions Delivers Savings of \$88 per Episode and High Patient Approval", *Health Affairs*, 32 No 2 (2013).
- 8 Prices are based on publicly available data for a patient with or without insurance. Actual co-pays may differ based on type of insurance. The prices do not include other factors such as cost sharing or rebates and may not reflect the true costs. Prices include only physician visit services and do not include lab diagnostics or other specialized procedures. Prices from 2008-2013 were gathered from publicly available sources such as websites for specific retail clinics, urgent care centers, and e-visits. Prices for physician office and emergency room visits were obtained from published articles and publicly available data from sources such as the American Hospital Association. (e-visits n=3, retail n=9, urgent n=4, physician n=3, emergency room n=4).
- 9 Campbell-Scherer D, "Multimorbidity: A Challenge for Evidence-Based Medicine," *Evidence-Based Med* 2010;15(6):165-66.
- 10 Institute of Medicine, "Living Well with Chronic Illness: A Call for Public Health Action," National Academic Press 2012 and National Health Expenditures Data 2011.
- 11 Meyer H, "Return of narrow network," *Managed Healthcare Executive*, 1 July 2012. <http://managed-healthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/return-narrow-network>
- 12 Page L, "7 Points About Cleveland Clinic's Bundled Payment Program for Lowe's Employees," *Beckers Hospital Review*, 11 October 2010.
- 13 Gamble M, "Cleveland Clinic Strikes Bundled Payment Deal With Boeing", *Beckers Hospital Review*, 19 October 2012.
- 14 "Companies Search for Fixed Rate Surgeries," *Medical Tourism Magazine*, 14 January 2013.
- 15 Johns Hopkins Medicine News, "PepsiCo Agreement Makes a Splash," 1 February 2012.
- 16 "Diabetes Integrated Practice Unite Pilot Project: Collaboration of Michelin, Bon Secours, United Healthcare, Medco, and Porter/Teisberg/Wallace."
- 17 Terhune C, "Companies Go Surgery Shopping," *Los Angeles Times*, 17 Nov 2012.
- 18 Silverman R, "Peeling Off a Service Line How Hoag Reinvented Orthopedics," *ImagingBiz*, 3 March 2012.
- 19 Terhune C. "Companies Go Surgery Shopping," *Los Angeles Times*. 17 Nov 2012.
- 20 Kroger Presentation, National Business Group on Health, May 2013.
- 21 A publication analysis search was done using a key word search for hospital readmissions through Factiva. Publications include all licensed Factiva sources.
- 22 Ladermann M, Loehrer S, McCarthy D, "The Effect of Medicare Readmissions Penalties on Hospitals' Efforts to Reduce Readmissions: Perspectives from the Field," *The Commonwealth Fund*. 26 Feb 2013.
- 23 Robert Wood Johnson Foundation, "The Revolving Door: A Report on U.S. Hospital Readmissions", February 2013.
- 24 CMS, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," April 2010. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf
- 25 Healthcare Intelligence Network, Reducing Hospital Readmissions in 2012 Survey
- 26 <http://www.medicare.gov/HospitalCompare/About/HOSInfo/Survey-Patients-Experience.aspx>
- 27 <http://www.qualitynet.org/dcs/>
- 28 <http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPages%2FQnet-Tier4&cid=1228695492636>
- 29 <http://www.consumerreports.org/cro/magazine/2012/08/how-safe-is-your-hospital/index.htm>
- 30 <http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2013/02/interactive-map-the-revolving-door-syndrome.html>
- 31 "Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care", *RAND Health*, 2012.

- 32 Haviland AM, Marquis MS, McDevitt RD, Sood N, "Growth of Consumer-Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save \$57 Billion Annually", *Health Affairs*, 31 No 5 (2012).
- 33 "Health Insurance Exchanges: Long on options, short on time," PwC Health Research Institute, October 2012.
- 34 First-time generic drugs are those drug products that have never been approved before as generic drug products and are new generic products to the marketplace. These may include multiple versions of an equivalent drug from different manufacturers.
- 35 Specialty medications include injectable and noninjectable drugs that are typically used to treat chronic, complex conditions and may have one or more of the following qualities: frequent dosing adjustments or intensive clinical monitoring; intensive patient training and compliance assistance; limited distribution; and specialized handling or administration.
- 36 EvaluatePharma. <http://www.gabionline.net/Biosimilars/Research/Biologicals-boom>
- 37 Express Scripts 2011 and 2012 Drug Trend Report. Pharmacy benefit spend which does not include the roughly 47% specialty drugs used for medical benefit (drugs delivered in outpatient physician settings).
- 38 Hernandez A, "Strategic Approaches for the Distribution of Specialty Pharmaceuticals" *Specialty Pharmacy Times*, 20 Dec 2012.
- 39 Jackson Healthcare, Trend Watch: Physician Practice Acquisitions 2012-2013. <http://www.jacksonhealthcare.com/media-room/surveys/trend-watch-physician-practice-acquisitions-2012-2013.aspx>
- 40 Robert Wood Johnson Foundation, "The impact of hospital consolidation—Update", June 2012.
- 41 The Massachusetts Experience: Employer-sponsored health insurance post reform, PwC Health Research Institute, May 2013.
- 42 Colla et al, "Spending differences associated with medicare physician group practice demonstration." *JAMA*, Vol 308, No. 10, 12 September 2012.
- 43 Song et al, "Health care spending and quality in year 1 of the alternative quality contract," *NEJM*, vol. 10, 8 September 2011.
- 44 Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce. Bureau of Economic Analysis; and U.S. Bureau of the Census: data obtained in April 2013.
- 45 Health Insurance Exchanges: Long on options, short on time, PwC Health Research Institute, October 2012.
- 46 The Massachusetts Experience: New wave of consolidation for health sector post reform, PwC Health Research Institute, May 2013.
- 47 PwC 2013 Health and Well-Being Touchstone Survey (large employer > 1,000 employees, small employer <1,000 employees).
- 48 Beeuwkes Buntin M, Haviland AM, McDevitt R, and Sood N, "Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans." *American Journal of Managed Care*, Vol. 17, No. 3, March 2011.
- 49 "Solving the talent equation for health IT," PwC Health Research Institute, March 2013.
- 50 "New Chemistry: Getting the biopharmaceutical talent formula right," PwC Health Research Institute, February 2013.

Acknowledgements

Helen Darling
President and CEO
National Business Group on Health

Mary Grealy
President
Healthcare Leadership Council

Mark D. Birdwhistell
Vice President, Administration and
External Affairs
UK HealthCare

Aslam Khan, MD
National Medical Officer
Cigna

Charles Roehrig
Vice President, Health Care
Economics; Director, Center for
Sustainable Health Spending
Altarum Institute

Paul Hughes-Cromwick
Health Economist and Senior
Analyst, Center for Sustainable
Health Spending
Altarum Institute

George Miller
Altarum Institute Fellow
Alatrum Institute

Cori Uccello
Senior Health Fellow
American Academy of Actuaries

Randy Moon
Vice President of International HR,
Benefits, and HRIS
Lowe's Companies, Inc.

About this research

Each year, PwC's Health Research Institute provides estimates on the growth of private medical costs over the next year and what the leading drivers of the trend are expected to be. Insurance companies use medical cost trend to help set premiums by estimating what the same health plan this year would cost the following year. In turn, employers use the information to make adjustments in benefit plan design to help offset cost increases. The report identifies and explains what it refers to as "inflators" and "deflators" to describe why and how medical cost trend is impacted.

This forward-looking report is based on the best available information through May 2013. HRI conducted interviews in March and April 2013 with 10 health plan officials (whose companies cover a combined 95 million people) about their estimates for 2014 and the factors driving those trends. Findings from PwC's Health and Well-Being Touchstone Survey of 1,047 employers from over 35 industries are also included. HRI also examined government data sources, journal articles, and conference proceedings in determining medical cost trend.

Behind the Numbers 2014 is our eighth report in this series.

About PwC

PwC US helps organizations and individuals create the value they're looking for. We're a member of the PwC network of firms in 158 countries with more than 180,000 people. We're committed to delivering quality in assurance, tax and advisory services. Tell us what matters to you and find out more by visiting us at www.pwc.com/us.

About Health Research Institute

PwC's Health Research Institute provides new intelligence, perspectives, and analysis on trends affecting all health-related industries. The Health Research Institute helps executive decision makers navigate change through primary research and collaborative exchange. Our views are shaped by a network of professionals with executive and day-to-day experience in the health industry. HRI research is independent and not sponsored by businesses, government, or other institutions.

**PwC Health
Research Institute**

Kelly Barnes
Partner
Health Industries Leader
kelly.a.barnes@us.pwc.com
(214) 754 5172

David Chin, MD
Principal (retired)
david.chin@us.pwc.com
(617) 530 4381

Ceci Connolly
HRI Managing Director
ceci.connolly@us.pwc.com
(202) 312 7910

Trine Tsouderos
Director
trine.k.tsouderos@us.pwc.com
(312) 298 3038

Sarah Haflett
Senior Manager
sarah.e.haflett@us.pwc.com
(267) 330 1654

Christopher Khoury
Senior Manager
christopher.m.khoury@us.pwc.com
(202) 312 7954

Regina Rights, PhD
Research Analyst
regina.m.rights@us.pwc.com
(615) 708 0058

Dana Jean-Baptiste
Research Analyst
dana.jean-baptiste@us.pwc.com
(678) 419 1265

HRI Regulatory Center

Benjamin Isgur
Director
benjamin.isgur@us.pwc.com
(214) 754 5091

Bobby Clark
Senior Manager
robert.j.clark@us.pwc.com
(202) 312 7947

Matthew DoBias
Senior Manager
matthew.r.dobias@us.pwc.com
(202) 312 7946

Caitlin Sweany
Senior Manager
caitlin.sweany@us.pwc.com
(202) 346-5241

HRI Advisory Team

Michael Thompson
Principal
michael.thompson@us.pwc.com
(646) 471 0720

Rick Judy
Principal
richard.m.judy@us.pwc.com
(310) 617 5567

John Stenson
Principal
john.stenson@us.pwc.com
(678) 419 1216

Jim Prutow
Principal
jim.prutow@us.pwc.com
(858) 677 2655

Barbara P Gniewek
Principal
(646) 471 8301
barbara.p.gniewek@us.pwc.com

Jack Rodgers, PhD
Managing Director
jack.rodgers@us.pwc.com
(202) 414 1646

Kulleni Gebreyes, MD
Director
kulleni.gebreyes@us.pwc.com
(703) 918 6676

Kristen Soderberg
Manager
kristen.a.soderberg@us.pwc.com
(202) 346 5143

**www.pwc.com/us/healthindustries
www.pwc.com/hri
twitter.com/PwCHealth**

.....
**To have a deeper conversation
about how this subject may affect
your business, please contact:**

Kelly Barnes
Partner, Health Industries Leader
kelly.a.barnes@us.pwc.com
(214) 754 5172

Michael Thompson
Principal
michael.thompson@us.pwc.com
(646) 471 0720

Rick Judy
Principal
richard.m.judy@us.pwc.com
(310) 617 5567

Ceci Connolly
HRI Managing Director
ceci.connolly@us.pwc.com
(202) 312 7910

ATTACHMENT L

UTILITY STOCKS AND THE SIZE EFFECT: AN EMPIRICAL ANALYSIS

Annie Wong*

I. Introduction

The objective of this study is to examine whether the firm size effect exists in the public utility industry. Public utilities are regulated by federal, municipal, and state authorities. Every state has a public service commission with board and varying powers. Often their task is to estimate a fair rate of return to a utility's stockholders in order to determine the rates charged by the utility. The legal principles underlying rate regulation are that "the return to the equity owner should be commensurate with returns on investments in other enterprises having corresponding risks," and that the return to a utility should be sufficient to "attract capital and maintain credit worthiness." However, difficulties arise from the ambiguous interpretation of the legal definition of *fair and reasonable rate of return* to an equity owner.

Some finance researchers have suggested that the Capital Asset Pricing Model (CAPM) should be used in rate regulation because the CAPM beta can serve as a risk measure, thus making risk comparisons possible. This approach is consistent with the spirit of a Supreme Court ruling that equity owners sharing similar level of risk should be compensated by similar rate of return.

The empirical studies of Banz (1981) and Reinganum (1981) showed that small firms tend to earn higher returns than large firms after adjusting for beta. This phenomenon leads to the proposition that firm size is a proxy for omitted risk factors in determining stock returns. Barry and Brown (1984) and Brauer (1986) suggested that the omitted risk factor could be the differential information environment between small and large firms. Their argument is based on the fact that investors often have less publicly available information to assess the future cash flows of small firms than that of large

firms. Therefore, an additional risk premium should be included to determine the appropriate rate of return to shareholders of small firms.

The samples used in prior studies are dominated by industrial firms, no one has examined the size effect in public utilities. The objective of this study is to extend the empirical findings of the existing studies by investigating whether the size effect is also present in the utility industry. The findings of this study have important implications for investors, public utility firms, and state regulatory agencies. If the size effect does exist in the utility industry, this would suggest that the size factor should be considered when the CAPM is being used to determine the fair rate of return for public utilities in regulatory proceedings.

II. Information Environment of Public Utilities

In general, utilities differ from industrials in that utilities are heavily regulated and they follow similar accounting procedures. A public utility's financial reporting is mainly regulated by the Securities and Exchange Commission (SEC) and the Federal Energy Regulatory Commission (FERC). Under the Public Utility Holding Company Act of 1935, the SEC is empowered to regulate the holding company systems of electric and gas utilities. The Act requires registration of public utility holding companies with the SEC. Only under strict conditions would the purchase, sale or issuance of securities by these holding companies be permitted. The purpose of the Act is to keep the SEC and investors informed of the financial conditions of these firms. Moreover, the FERC is in charge of the interstate operations of electric and gas companies. It requires utilities to follow the accounting procedures set forth in its Uniform Systems of Accounts. In particular, electric and gas utilities must request their Certified Public Accountants to certify that certain schedules in the financial reports are in conformity with the Commission's accounting requirements. These detailed reports are submitted annually and are open to the public.

*Western Connecticut State University. The author thanks Philip Perry, Robert Hagerman, Eric Press, the anonymous referee, and Clay Singleton for their helpful comments.

The FERC requires public utilities to keep accurate records of revenues, operating costs, depreciation expenses, and investment in plant and equipment. Specific financial accounting standards for these purposes are also issued by the Financial Accounting Standards Board (FASB). Uniformity is required so that utilities are not subject to different accounting regulations in each of the states in which they operate. The ultimate objective is to achieve comparability in financial reporting so that factual matters are not hidden from the public view by accounting flexibility.

Other regulatory reports tend to provide additional financial information about utilities. For example, utilities are required to file the FERC Form No. 1 with the state commission. This form is designed for state commissions to collect financial and operational information about utilities, and serves as a source for statistical reports published by state commissions.

Unlike industrials, a utility's earnings are predetermined to a certain extent. Before allowed earnings requests are approved, a utility's performance is analyzed in depth by the state commission, interest groups, and other witnesses. This process leads to the disclosure of substantial amount of information.

III. Hypothesis and Objective

Due to the Act of 1935, the Uniform Systems of Accounts, the uniform disclosure requirements, and the predetermined earnings, all utilities are reasonably homogeneous with respect to the information available to the public. Barry and Brown (1984) and Brauer (1986) suggested that the difference of risk-adjusted returns between small and large firms is due to their differential information environment. Assuming that the differential information hypothesis is true, then uniformity of information availability among utility firms would suggest that the size effect should not be observed in the public utility industry. The objective of this paper is to provide a test of the size effect in public utilities.

IV. Methodology

1. Sample and Data

To test for the size effect, a sample of public utilities and a sample of industrials matched by equity value are formed so that their results can be compared. Companies in both samples are listed on the Center for Research in Security Prices (CRSP)

Daily and Monthly Returns files. The utility sample includes 152 electric and gas companies. For each utility in the sample, two industrial firms with similar firm size (one is slightly larger and the other is slightly smaller than the utility) are selected. Thus, the industrial sample includes 304 non-regulated firms.

The size variable is defined as the natural logarithm of market value of equity at the beginning of each year. Both the equally-weighted and value-weighted CRSP indices are employed as proxies for the market returns. Daily, weekly and monthly returns are used. The Fama-MacBeth (1973) procedure is utilized to examine the relation between risk-adjusted returns and firm size.

2. Research Design

All utilities in the sample are ranked according to the equity size at the beginning of the year, and the distribution is broken down into deciles. Decile one contains the stocks with the lowest market values while decile ten contains those with the highest market values. These portfolios are denoted by MV_1 , MV_2 , ..., and MV_{10} , respectively.

The combinations of the ten portfolios are updated annually. In the year after a portfolio is formed, equally-weighted portfolio returns are computed by combining the returns of the component stocks within the portfolio. The betas for each portfolio at year t , $\hat{\beta}_p$'s, are estimated by regressing the previous five years of portfolio returns on market returns:

$$\bar{R}_p = \alpha_p + \hat{\beta}_p \bar{R}_m + \bar{U}_p \quad (1)$$

where

R_p = periodic return in year t on portfolio p

R_m = periodic market return in year t

U_p = disturbance term.

Banz (1981) applied both the ordinary and generalized least squares regressions to estimate β ; and concluded that the results are essentially identical (p.8). Since adjusting for heteroscedasticity does not necessarily lead to more efficient estimators, the ordinary least squares procedures are used in this study to estimate β in equation (1).

The following cross-sectional regression is then run for the portfolios to estimate γ_i , $i = 0, 1$, and 2 :

$$R_{pt} = \gamma_0 + \gamma_1 \hat{\beta}_{pt} + \gamma_2 \hat{S}_{pt} + U_{pt} \quad (2)$$

where

$\hat{\beta}_{pt}$ = estimated beta for portfolio p at year t, t=1968, ..., 1987

\hat{S}_{pt} = mean of the logarithm of firm size in portfolio p at the beginning of year t

U_{pt} = disturbance term.

Depending on whether daily, weekly or monthly returns are used, a portfolio's average return changes periodically while its beta and size only change once a year. The γ_1 and γ_2 coefficients are estimated over the following four subperiods: 1968-72, 1973-77, 1978-82 and 1983-1987. If portfolio betas can fully account for the differences in returns, one would expect the average coefficient for the beta variable to be positive and for the size variable to be zero. A t-statistic will be used to test the hypothesis. The coefficients of a matched sample are also examined so that the results between industrial and utility firms can be compared.

V. Analysis of Results

1. Equity Value of the Utility Portfolios

The mean equity values of the ten size-based utility portfolios are reported in Table 1. Panels A and B present the average firm size of these portfolios at the beginning and end of the test period, 1968-1987. The first interesting observation from Table 1 is that the difference in magnitude between the smallest and the largest market value utility portfolios is tremendous. In Panel A, the average size of MV_1 is about \$31 million while that of MV_{10} is over \$1.4 billion. In Panel B, that is twenty years later, they are \$62 million and \$5.2 billion, respectively. Another interesting finding is that there is a substantial increase in average firm size from MV_9 to MV_{10} . Since these two findings are consistent over the entire test period, the average portfolio market values for interim years are not reported. These results are similar to the empirical evidence provided by Reinganum (1981).

The utility sample in this study contains 152 firms whereas Reinganum's sample contains 535 firms that are mainly industrial companies. Two conclusions may be drawn from the results of the Reinganum study and this one. First, utilities and industrials are similar in the sense that their market

values vary over a wide spectrum. Second, the fact that there is a huge jump in firm size from MV_9 to MV_{10} indicates that the distribution of firm size is positively skewed. To correct for the skewness problem, the natural logarithm of the mean equity value of each portfolio is calculated. This variable is then used in later regressions instead of the actual mean equity value.

2. Betas of the Utility and Industrial Samples

The betas based on monthly, weekly and daily returns are reported for the utility and industrial samples. For simplicity, they will be referred to as monthly, weekly, and daily betas. In all cases, five years of returns are used to estimate the systematic risk. The betas estimated over the 1963-67 time period are used to proxy for the betas in 1968, which is the beginning of the test period. By the same token, the betas obtained from the time period 1982-86 are used as proxies for the betas in 1987, which is the end of the test period.

The betas from using the equally-weighted and value-weighted indices are calculated in order to check whether the results are affected by the choice of market index. Since the results are similar, only those obtained from the equally-weighted index are reported and analyzed.

Table 2 reports the monthly, weekly and daily betas of the two samples at the beginning and end of the test period. Panel A shows the various betas of the industrial portfolios. Two conclusions may be drawn. First, in the 1960's, smaller market value portfolios tend to have relatively larger betas. This is consistent with the empirical findings by Banz (1981) and Reinganum (1981). Second, this trend seems to vanish in the 1980's, especially when weekly and daily returns are used.

The betas of the utility portfolios are presented in Panel B. The table shows that none of the utility betas are greater than 0.71. A comparison between Panels A and B reveals that utility portfolios are relatively less risky than industrial portfolios after controlling for firm size. The comparison also reveals that, unlike industrial stocks, betas of the utility portfolios are not related to the market values of equity.

The negative correlation between firm size and beta in the industrial sample may introduce a multicollinearity problem in estimating equation (2). Banz (p.11) had addressed this issue and concluded that the test results are not sensitive to the

multicollinearity problem. For the utility sample, this problem does not exist.

3. Tests on the Coefficients of Beta and Size

The beta and firm size are used to estimate γ_1 and γ_2 in equation (2). A t-statistic is used to test if the mean values of the gammas are significantly different from zero. The tests were performed for four 5-year periods which are reported in Table 3. The mean of the gammas and their t-statistic are presented in Panel A for the utilities and in Panel B for the industrial firms.

The empirical results for the utility sample are reported in Panel A of Table 3. When monthly returns are used, 60 regressions were run to obtain 60 pairs of gammas for each of the 5-year periods. When daily returns are used, over 1200 regressions were run for each period to obtain the gammas. The results are similar: in all of the time periods tested, none of the average coefficients for beta and size are significantly different from zero. When weekly returns are used, 260 pairs of gammas were obtained. The average coefficients for beta are not significant in any test period, and the average coefficients for size are not significant in three of the test periods. For the test period of 1978-82, the average coefficient for size is significantly negative at a 5% level.

The test results for the industrial sample are reported in Panel B of Table 3. When monthly returns are used, the average coefficient estimates for size and beta are significant and have the expected sign only in the 1983-87 test period. When weekly returns are used, only the size variable is significantly negative in the 1978-82 period. When daily returns are used, the coefficient estimates for betas and size are not significant at any conventional level.

According to the CAPM, beta is the sole determinant of stock returns. It is expected that the coefficient for beta is significantly positive. However, the empirical findings reported in this study and in Fama and French (1992) only provide weak support for beta in explaining stock returns. The empirical findings in this study also suggest that the size effect varies over time. It is not unusual to document the firm size effect at certain time periods but not at others. Banz (1981) found that the size effect is not stable over time with substantial differences in the magnitude of the coefficient of the size factor (p.9, Table 1). Brown, Kleidon and Marsh (1983) not only have shown that size effect is not constant over time but also have reported a reversal of the size anomaly for certain years.

The research design of this study allows us to keep the sample, test period, and methodology the same with the holding-period being the only variable. The size effect is documented for the industrial sample in one of the four test periods when monthly returns are used and in another when weekly returns are used. When daily returns are used, no size effect is observed. For the utility sample, the size effect is significant in only one test period when weekly returns are used. When monthly and daily returns are used, no size effect is found. Therefore, this study concludes that the size effect is not only time-period specific but also holding-period specific.

VI. Concluding Remarks

The fact that the two samples show different, though weak, results indicates that utility and industrial stocks do not share the same characteristics. First, given firm size, utility stocks are consistently less risky than industrial stocks. Second, industrial betas tend to decrease with firm size but utility betas do not. These findings may be attributed to the fact that all public utilities operate in an environment with regional monopolistic power and regulated financial structure. As a result, the business and financial risks are very similar among the utilities regardless of their sizes. Therefore, utility betas would not necessarily be expected to be related to firm size.

The objective of this study is to examine if the size effect exists in the utility industry. After controlling for equity values, there is some weak evidence that firm size is a missing factor from the CAPM for the industrial but not for the utility stocks. This implies that although the size phenomenon has been strongly documented for the industrials, the findings suggest that there is no need to adjust for the firm size in utility rate regulations.

References

- Banz, R.W. "The Relationship Between Return and Market Value of Common Stocks," *Journal of Financial Economics*, (March 1981): 3-18.
- Barry, C.B. and S.J. Brown. "Differential Information and the Small Firm Effect," *Journal of Financial Economics*, (1984): 283-294.
- Brauer, G.A. "Using Jump-Diffusion Return Models to Measure Differential Information by Firm

- Size," *Journal of Financial and Quantitative Analysis*, (December 1986): 447-458.
- Brown, P., A.W. Kleidon, and T.A. Marsh. "New Evidence on the Nature and Size Related Anomalies in Stock Prices," *Journal of Financial Economics*, (1983): 33-56.
- Fama, E.F. and K.R. French. "The Cross-Section of Expected Stock Returns," *Journal of Finance*, (June 1992): 427-465.
- Fama, E.F. and J.D. MacBeth. "Risk Return and Equilibrium: Empirical Tests," *Journal of Political Economy*, (May/June 1973): 607-636.
- Reinganum, M.R. "Misspecification of Capital Asset Pricing: Empirical Anomalies Based on Earnings' Yields and Market Values," *Journal of Financial Economics*, (March 1981): 19-46.

Table 1

Average Equity Size of the Utility Portfolios at the Beginning and End of the Test Period
(Dollar figures in millions)

	A: Beginning (1968)	B: End (1987)
MV ₁	\$31	\$62
MV ₂	\$77	\$177
MV ₃	\$113	\$334
MV ₄	\$161	\$475
MV ₅	\$220	\$715
MV ₆	\$334	\$957
MV ₇	\$437	\$1,279
MV ₈	\$505	\$1,805
MV ₉	\$791	\$2,665
MV ₁₀	\$1,447	\$5,399

Table 2

Betas of the Two Samples at the Beginning and End of the Test Period

	<u>Monthly Betas</u>		<u>Weekly Betas</u>		<u>Daily Betas</u>	
	1963-67	1982-86	1963-67	1982-86	1963-67	1982-86
Panel A: Industrial Firms						
MV ₁	0.89	1.00	1.15	0.95	1.11	0.92
MV ₂	0.94	0.87	1.07	1.01	1.14	1.01
MV ₃	0.88	0.82	1.12	0.86	1.14	1.04
MV ₄	0.69	0.74	1.00	0.83	1.03	0.86
MV ₅	0.73	0.80	1.05	0.96	1.13	1.01
MV ₆	0.66	0.82	1.03	1.01	1.05	1.04
MV ₇	0.64	0.81	0.97	1.04	0.98	1.09
MV ₈	0.62	0.75	0.97	1.11	1.00	1.20
MV ₉	0.52	0.78	0.84	1.06	0.94	1.16
MV ₁₀	0.43	0.65	0.78	1.01	0.86	1.22
Panel B: Public Utilities						
MV ₁	0.30	0.37	0.31	0.43	0.30	0.40
MV ₂	0.28	0.38	0.37	0.47	0.36	0.44
MV ₃	0.22	0.42	0.33	0.42	0.31	0.49
MV ₄	0.27	0.35	0.36	0.52	0.34	0.54
MV ₅	0.25	0.45	0.37	0.61	0.35	0.62
MV ₆	0.25	0.41	0.39	0.54	0.40	0.65
MV ₇	0.20	0.35	0.34	0.54	0.37	0.63
MV ₈	0.17	0.38	0.34	0.65	0.33	0.68
MV ₉	0.19	0.34	0.35	0.60	0.34	0.71
MV ₁₀	0.18	0.29	0.38	0.59	0.39	0.71

Table 3

Tests on the Mean Coefficients of Beta (γ_1) and Size (γ_2)

$$R_{pt} = \gamma_\alpha + \gamma_1 \hat{\beta}_{pt} + \gamma_2 \hat{S}_{pt} + U_{pt}$$

Returns Used:		Monthly (t-value)	Weekly (t-value)	Daily (t-value)
Panel A: Utility Sample				
1968-72	γ_1	-0.46% (-0.26)	-0.32% (-0.42)	-0.02% (-0.18)
	γ_2	-0.07% (-0.78)	-0.01% (-0.51)	-0.00% (-0.46)
1973-77	γ_1	-0.28% (-0.13)	0.14% (0.14)	-0.03% (-0.21)
	γ_2	-0.11% (-0.70)	-0.03% (-0.67)	-0.00% (-0.53)
1978-82	γ_1	0.55% (0.36)	0.54% (1.00)	0.05% (0.43)
	γ_2	-0.10% (-0.75)	-0.05% (-1.71)*	-0.01% (-1.60)
1983-87	γ_1	1.74% (1.28)	-0.24% (-0.51)	-0.02% (-0.18)
	γ_2	-0.16% (-1.54)	-0.03% (-0.86)	-0.01% (-0.63)
Panel B: Industrial Sample				
1968-72	γ_1	-0.36% (-0.27)	-0.28% (-0.55)	-0.02% (-0.32)
	γ_2	0.07% (0.43)	-0.01% (-0.19)	0.00% (0.51)
1973-77	γ_1	1.34% (0.64)	-0.23% (-0.31)	0.14% (1.45)
	γ_2	-0.01% (-0.06)	-0.04% (-0.85)	-0.00% (-0.64)
1978-82	γ_1	-0.84% (-0.28)	-0.56% (-0.91)	-0.09% (-0.81)
	γ_2	-0.29% (-0.75)	-0.01% (-1.72)*	-0.00% (-1.33)
1983-87	γ_1	2.51% (1.83)*	0.34% (0.64)	0.11% (1.40)
	γ_2	-0.25% (-1.90)*	-0.01% (-0.43)	0.00% (0.14)

* Significant at the 5% level based on a one-tailed test.