MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
NOVEMBER 16, 2020

The State Employee Benefits Committee (the "Committee") met at 2:00 p.m. on November 16, 2020. In accordance with the Proclamation Authorizing Public Bodies to Meet Electronically and in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, this meeting was conducted via WebEx, without a physical location.

Committee Members Represented or in Attendance:
Secretary Saundra Johnson, Department of Human Resources ("DHR"), Co-Chair
Dir. Michael Jackson, Office of Management & Budget ("OMB"), (Co-Chair)
The Honorable Bethany Hall-Long, Lieutenant Governor, Office of the Lt. Governor
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer
The Honorable Trinidad Navarro, Insurance Commissioner, Department of Insurance
Secretary Molly Magarik, Department of Health & Social Services ("DHSS")
Controller General Mike Morton, Office of the Controller General
Ms. Evelyn Nestlerode, Deputy State Court Administrator, Administrative Office of the Courts (Designee OBO The Honorable Collins Seitz, Chief Justice, Delaware Supreme Court)
Mr. Jeff Taschner, Executive Director, Delaware State Education Association (Appointee of the Governor)

Others in Attendance:
Director Faith Rentz, Statewide Benefits Office ("SBO"), DHR
Deputy Director Leighann Hinkle, SBO, DHR
Deputy Secretary Tanisha Merced, DHSS
Deputy Attorney General, Andrew Kerber, Dept. of Justice, SEBC Legal Counsel
Mr. Chris Giovannello, Willis Towers Watson ("WTW")
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Ms. Joanna Adams, Pension Administrator, Office of Pensions
Ms. Amy Bonner, Deputy Director, OMB
Ms. Jennifer Bredemeier, University of Delaware
Ms. Christina Bryan, DE Healthcare Assoc.
Ms. Michelle Carpenter, PHRST
Ms. Julie Caynor, Aetna
Mr. Steven Costantino, Dir. Of Healthcare Reform, DHSS
Ms. Judy Grant, Health Advocate
Ms. Nina Figueroa, Health Policy Advisor, SBO, DHR
Ms. Sandy Hart, IBM Watson Health
Ms. Katherine Impellizzeri, Aetna
Ms. Heather Johnson, Controller, DHR
Ms. Megan Kucker, Public Member
Mr. Adam Knox, Highmark Delaware
Ms. Elizabeth Lewis, Hamilton Goodman Partners
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walt Mateja, IBM Watson Health
Ms. Emily Molinaro, Fiscal & Policy Analyst, OMB
Ms. Jennifer Mossman, Highmark Delaware
Mr. Michael North, Aetna
Ms. Pam Price, Highmark Delaware
Ms. Paula Roy, DE Chiropractic Services Network
Ms. Carrie Schiavo, Delta Dental
Ms. Judi Schock, Deputy Principal Asst., OMB
Ms. Martha Sturtevant, Exec. Sec., SBO, DHR -Recorder
Mr. Keith Warren, Chief of Staff, Office of the Lt. Governor

CALLED TO ORDER
Dir. Faith Rentz called the meeting to order at 2:00 p.m. and introductions were made.

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APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ
A MOTION was made by Mr. Taschner and seconded by CG Morton to approve the minutes from the October 12, 2020 meeting of the State Employee Benefits Committee.
MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ
SEBC Co-Chairs, Dir. Mike Jackson and Secretary Saundra Johnson will be leaving the Committee in January. The official transitions will take place with the Senate confirmations of Amy Bonner (DHR) and Cerron Cade (OMB) in January 2021. SBO will coordinate transition meetings. Additionally, Mr. Kevin Fyock has left the WTW team to pursue other opportunities.

SBO Updates:
SBO has been working with the State's Disability Insurance Program Administrator, The Hartford, during the transition to a new administrative platform. SBO continues to work closely with the Group Health Insurance Program ("GHIP") organizations related to access, navigation and troubleshooting. All Short Term Disability ("STD") Program claims received on or after the November 2, 2020 transition will be submitted on the new platform. All claims opened prior to this date continue to be accessed through the retiring platform.

SBO continues to work on the transition of the Employee Assistance Program ("EAP") services from HealthAdvocate to ComPsych effective January 1, 2021. Orientation webinars have been scheduled in early December for managers and for employees. Registration information has been emailed to organizations and benefit eligible employees, as well as posted on the SBO website. Direct home mailings, posters and wallet cards will be distributed the week of January 4, 2021.

RFP Updates:
The Proposal Review Committee expects to conclude their work on the Request for Proposal ("RFP") for Pharmacy Benefit Manager services and for data analytics/warehouse services. The contract award recommendations are being prepared to be presented for the Committee's consideration on December 16, 2020.

The Health Care Stakeholder Request for Information has received communications from more than a dozen organizations who have indicated their intent to provide a response by the December 1, 2020 deadline.

Subcommittee Updates:
The Financial Subcommittee met on November 12, 2020 (the Health Policy and Planning Subcommittee was also invited to attend) to review the FY21 Q1 financial updates and to review the FY20 outcomes specific to site of care, maternity and infertility benefits, and infusion therapy utilization.

The Subcommittees will meet in December to discuss outcomes of the care management programs (Livongo and SurgeryPlus) and to review FY22 program recommendations.

Insurance Commissioner Navarro joined the meeting.

FINANCIALS
September Fund Equity Report – Chris Giovannello, WTW
Revenue was consistent with budget. Claims were $275K below budget and the YTD claim differential was $11.2M below budget. The YTD fund equity balance is $186.9M with a variance to budget of $8.3M driven by favorable claims experience in Q1.

FY21 Q1 Financial Reporting – Chris Giovannello, WTW
Members reviewed financial reporting comparing Q1 of FY20 to Q1 of FY21.

Gross claims include paid medical and pharmacy claims as reported by Aetna, Highmark, and Express Scripts. Overall gross claims were down 2.2%. Medical costs are up 0.5% driven by an increase in membership. Prescription claims decreased by 7.4% as a result of invoice timing.

The total cost per employee per year and per member per year is down 4.0% and 3.7% respectively, primarily a result of invoice timing and deferred care. FY21 program costs compared to budget are down 8.8%.

The COVID-19 pandemic has had a significant impact on utilization. Visits are down for well-baby (-4.6%), well-child (-2.5%) and preventive adult (-15.6%). There were reduced screening rates for cholesterol and cancer. There was an 8.0% reduction in inpatient admits, and a 14.2% reduction in emergency room visits.

Pharmacy claims were not impacted by COVID-19. There was a 2.6% increase in cost and utilization of all prescriptions. Specialty medication utilization increased by 21.2% and now makes up 45% of pharmacy spend.

Total program costs of $910.6M are projected for FY21

The FY21 YTD Reporting reconciliation reflects and extra invoice on the medical side that is not reflected in the FY21 Q1 financial report.

GHIP Long-tern Projections as of FY21 Q1– Ms. Rebecca Warnken and Chris Giovannello, WTW
Members reviewed emerging experience from COVID-19 claims through FY21 Q1.

The cost of deferred care continues to outpace costs related to the testing and treatment of COVID-19. New claims have risen higher than pre-pandemic levels as deferred care returns; however, a rise in new cases may result in new deferred care.

The potential for new waves of infection and the cost and effectiveness of vaccines will affect the impact the GHIP in FY21 and beyond. WTW recommends that the $23.5M one-time reserve be held aside from the fund reserve.

FY20 Q4 claims came in $47.1M below budget and FY21 Q1 claims came in $11.2M below budget, however; October claims exceeded budget by $5.1M for the first time since the pandemic began. To date November invoices received for Highmark and Aetna are higher than budgeted. Claims are projected to continue to exceed budget through 2021.

Highmark YTD COVID-19 non-test paid claims is $4.9M (confirmed), with $6.0M in test paid claims.

Aetna YTD COVID-19 non-test paid claims is $1.4M, with $543K in test paid claims.

Monthly expenses attributable to COVID-19 continue to increase. Actual YTD GHIP spend attributable to the pandemic is $12.8M, up $4.2M from September.

Dir. Jackson queried the definitions of non-test and test paid claims. Mr. Giovannello responded that non-test paid claims refer to testing for confirmed COVID-19 cases, and test paid claims refer to procedure codes used for COVID-19 and anti-body testing.

Dir. Jackson queried whether there have been conversations regarding the GHIP receiving reimbursement from the Corona Virus Relief Fund. Dir. Rentz responded that claim data can be queried. Dir. Jackson requested further review of GHIP expenses related to testing for COVID-19 to evaluate whether they qualify for reimbursement.

The projected FY21 budget of $910.6M has been increased from the FY20 Q4 budget of $905.7M and assumes a 50% return of deferred care in FY20 Q4, as well as an adjustment of $2.6 resulting from lower than the expected 1% enrollment. The projections do not account for any reimbursement for COVID-19 testing claims.

The FY22 budget is projected to be $963.4M for a 5.8% increase over FY21.

The Financial Subcommittee recommended smoothing the surplus over a period of two years. The fund has been able to delay any rate action due to the claim levels running favorably during the pandemic, however; the surplus will be eroded quickly if claim levels return to pre-pandemic levels and rate action may be required in FY22.

In FY20 the fund ended the year with a surplus of $108.0M. Holding premium rates flat in FY21 and beyond is projected to reduce the surplus to $15.7M by the end of FY21 and projects a deficit of $79.0M by the end of FY22. The $23.5M COVID-19 reserve fund is not included in the FY22 deficit. The 11.1% change per member of GHIP claims projected in FY21 is due to the FY20 baseline reflecting a favorable year due to COVID-19 deferred care and projecting FY21 having anticipated higher than average claims.

Dir. Rentz queried how delaying the implementation date for rate action would impact the projections. Ms. Warnken responded that a delay of six months would require approximately a 20% rate increase to recuperate the target revenues that a 10.2% increase would provide if implemented on July 1, 2021.

Dir. Jackson queried the assumptions used to estimate the increase in operating costs per member in the last quarter of FY21. Mr. Giovannello responded that the forecast included an estimated $30.0M in expenses related to the return of differed care, or approximately 0.5% higher than a normal year absent COVID-19. Dir. Jackson cautioned Members to frequently monitor adjustments to the projections. Mr. Giovannello added that claims are now monitored on a weekly basis and Ms. Warnken acknowledged the potential for volatility.

A rate increase of 10.2% effective July 1, 2021 is needed to smooth the $15.7M surplus over two years and projects a $7.8M surplus through the end of FY22. With this option GHIP members would experience increases between $2.84 to $27.83 per month and the State's contributions will increase from $68.09 to $182.23 per employee per month depending on plan and coverage tier.

While not recommended, a rate increase of 9.3% effective July 1, 2021 would lead to a $0 surplus at the end of FY22. With this option GHIP members would experience increases between $2.59 to $25.38 per month and the State's contributions will increase from $62.08 to $166.14 per employee per month depending on plan and coverage tier.

Modeling assumes the COVID-19 Reserve is returned to the fund.

Emerging experience will continue to be monitored with projections revised monthly. Discussions will be ongoing regarding the timing and recommendations for future rate action.

Mr. Taschner queried whether plan design changes were under consideration that could be used to offset rate action alone. Ms. Warnken responded that the Subcommittees will be exploring options for plan design changes and there is potential for savings from upcoming RFPs.

GHIP/SBO STRATEGIC FRAMEWORK GOALS – MS. JACLYN IGLESIAS

There was a review of progress made toward the original GHIP Strategic Framework goals approved by the SEBC in December of 2016, as well as the SBO Strategic Plan.

The first goal to add at least one 1 value-based care delivery model by end of FY18 was met through the induction of AIM HMO model with CareVio risk sharing arrangement.

Since then there has been a greater willingness from medical providers and plan sponsors to opt into value-based contracting arrangements to steer participants to higher quality, cost-effective providers. There have also been national efforts to standardize the framework of provider payment models that are alternatives to fee-for-service reimbursement. In Delaware there has been increased interest in provider adoption of alternative payment models.

The goal was revised in February 2020 to increase the percent of total GHIP spend (Category 3: 40%, Category 4: 10%) channels through Advanced Payment Models ("APMs") using the APM Framework and FY21 medical spend as a baseline.

The second goal to reduce the gross GHIP medical and prescription drug trend by 2% by the end of FY20 (SBO strategic plan also incorporated this goal) was met by using the average trend of 6%. The annual increase for the GHIP gross claims per member was 2.7% (includes favorable impact of COVID-19 in Q4 FY20) and 3.9% (excludes Q4 FY20).

Throughout FY19 and FY20 there were significant increases in facility costs (inpatient admissions increased 14.4%) and specialty drugs dispensed through the medical provider or facility (dispensed through medical plan in an outpatient setting increased 88.5%).

Further attention was drawn to facility costs through research conducted by Johns Hopkins University on impatient hospital prices and margins in Delaware, and the RAND Corporation's study of health care paid by private plans relative to Medicare.

The goal was revised in February 2020 to limit the total cost of care inflation for GHIP participants at a level commensurate with the Delaware Health Care Spending Benchmark by the end of FY23 by focusing on (but not limited to) outpatient and impatient facility costs and pharmaceutical costs.

There is also an opportunity to use the Benchmark to focus on managing diabetes (which occurs at a higher rate in the GHIP), and to collaborate with other public health initiatives in Delaware. The baseline average annual cost increase for diabetic members from FY17 to FY20 was 7.2%.

As a result, a new goal was established in February 2020 to reduce the diabetic cost per member per month by 8% by the end of FY23, using FY21 spend as a baseline (SBO strategic plan incorporated the same goal but with a modified timeline ending FY20).

The final goal from the original Strategic Framework was for the total GHIP membership to exceed 25% enrolled in a consumer-driven or value-based plan by the end of FY20. As of the end of FY20, 29% of active employees and non-Medicare pensioners were enrolled in the CDH Gold Plan and the AIM HMO Plan.

The intention of this goal was to encourage greater employee engagement in their own health and health care usage; however, recently the emphasis has been on increasing member education and benefit literacy to motivate members to play a role in their own health care.

The goal was revised in February 2020 to drive an incremental increase in unique users utilizing a specific point of enrollment and/or point of care engagement platform/consumerism tool by at least 5% annually (SBO strategic plan incorporates the same goal).

Progress toward the updated goal will continue to be monitored and will continue to be reported to the Committee on a periodic basis.

Sec. Magarik urged the Committee to continue to look for and evaluate new opportunities that can meaningfully change the cost trajectory for the plan.

GROUP HEALTH INSURANCE PROGRAM ELIGIBILITY & ENROLLMENT RULES – DIR. FAITH RENTZ

Proposed changes to the Group Health Insurance Plan Eligibility and Enrollment Rules were reviewed with the Committee on October 12, 2020 and a copy of the tracked-changes was provided for the Committee's review. If approved, the changes will be submitted to the Registrar of Regulations for an effective date of December 1, 2020. The Committee had no further questions.

A MOTION was made by CG Morton and seconded by Sec. Magarik to approve the Group Health Insurance Plan Eligibility & Enrollment Rules.
MOTION ADOPTED UNANIMOUSLY

OTHER BUSINESS

No new business was presented.

PUBLIC COMMENT

Instructions were provided. No public comment was presented.

ADJOURNMENT

A MOTION was made by CG Morton and seconded by Lt. Governor Hall-Long to adjourn the meeting at 3:27 p.m.
MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

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Martha Sturtevant, Executive Secretary, Statewide Benefits Office, Department of Human Resources
Recorder, State Employee Benefits Committee and Subcommittees