MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
FEBRUARY 22, 2021

The State Employee Benefits Committee (the "Committee") met at 2:00 p.m. on February 22, 2021. 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 Amy Bonner, Department of Human Resources ("DHR"), Co-Chair
Director Cerron Cade, Office of Management & Budget ("OMB"), Co-Chair
The Honorable Bethany Hall-Long, Lieutenant Governor
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer ("OST")
The Honorable Trinidad Navarro, Insurance Commissioner
Controller General Ruth Ann Jones, Office of the Controller General ("OCG")
Secretary Molly Magarik, Department of Health & Social Services ("DHSS")
Mr. Jeff Taschner, Executive Director, Delaware State Education Association ("DSEA") (Appointee of the Governor)
Ms. Ashley Tucker, Staff Attorney, Administrative Office of the Courts (Designee OBO The Honorable Collins Seitz, Chief Justice, Delaware Supreme Court)

Others in Attendance
Dir. Faith Rentz, Statewide Benefits Office ("SBO"), DHR
Deputy Director Leighann Hinkle, SBO, DHR
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. Debra Baustert, HRIS Specialist III, PHRST
Ms. Wendy Beck, Highmark Delaware
Ms. Rebecca Byrd, ByrdGomes Group
Ms. Victoria Brennan, Chief of Fiscal Policy, OCG
Ms. Michelle Carpenter, PHRST
Ms. Julie Caynor, Aetna
Mr. Steven Costantino, Dir. Healthcare Reform, DHSS
Ms. Cherie Dodge Biron, Deputy Principal Asst, DHR
Ms. Jacqueline Faulcon, READAA
Ms. Nina Figueroa, Health Policy Advisor, SBO, DHR
Ms. Nicole Freedman, Morris James
Ms. Sandy Hart, IBM Watson Health
Ms. Julie Greenwood, University of Delaware
Ms. Katherine Impellizzeri, Aetna
Ms. Heather Johnson, Controller II, DHR
Mr. Jamie Johnstone, Deputy Principal Asst., Dept of Finance ("DOF")
Mr. Adam Knox, Highmark Delaware
Ms. Lizzie Lewis, Hamilton Goodman Partners
Mr. Daniel Madrid, Chief Operating Officer, OST
Ms. Lisa Mantegna, Highmark Delaware
Ms. Mary Kate McLaughlin, Faegre Drinker Biddle Reath
Mr. Sean McNeely, Dir. Bond Finance, DOF
Mr. Walt Mateja, IBM Watson Health
Deputy Secretary Tanisha Merced, DHSS
Ms. Emily Molinaro, Fiscal & Policy Analyst, OMB
Ms. Jennifer Mossman, Highmark Delaware
Mr. Michael North, Aetna
Ms. Paula Roy, Roy & Associates
Ms. Carrie Schiavo, Delta Dental
Ms. Judi Schock, Deputy Principal Asst., OMB
Mr. Aaron Schrader, HR Manager, DHR, SBO
Mr. Bert Scoglietti, Deputy Controller General, OMB
Ms. Courtney Stewart, Deputy Director, OMB
Ms. Martha Sturtevant, Exec. Sec., SBO, DHR - Recorder, State Employee Benefits Committee and Subcommittees
Mr. James Testerman, DSEA Retired
Ms. Jules Villecco, Exec. Assist, DHSS
Mr. Keith Warren, Chief of Staff, Office of Lt. Gov.

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

APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ
A MOTION was made by Sec. Bonner and seconded by Lt. Governor Hall-Long to approve the minutes from the December 14, 2020 meeting of the State Employee Benefits Committee.
MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ
Rethink Family Support Benefits
The free trial benefits for Rethink family support benefits have been extended. SBO is evaluating options related to this benefit including responses received to the Request for Information ("RFI") released in January as well as related benefits and services available through the GHIP and other avenues outside of the GHIP.

Health Care Stakeholder RFI
SBO and WTW are evaluating 19 responses received from the RFI that closed December 1, 2020. SBO intends to update all respondents by March 1, 2021. There will be no contract awards from this RFI; however, findings will be used as key inputs for the upcoming medical Third Party Administrator Request for Proposal ("RFP") scheduled for release in Spring 2021; the current TPA contract expires June 2022.

New Benefits for 2021 Open Enrollment
Open Enrollment is scheduled for May 3 – 19, 2021. SBO is implementing a second EyeMed Vision offering and the transition from Express Scripts to CVS Caremark for pharmacy benefits, both effective July 1, 2021. The transition to CVS for the Medicare population will occur on January 1, 2022.

Legislative Updates
The Primary Care Reform Collaborative met January 25, 2021 to discuss potential legislation that would set a primary care target spend of 11.5%, increase primary care spending 1.5% annually thru 2025, and include an increase in primary care reimbursement in CY21 to 150% of Medicare spend. The components do not include any provisions to limit trend and unit cost growth in other areas of health care spend. SBO has provided comments and estimates for the fiscal impact to the GHIP range from $8.9M to $15.0M for FY22. A draft bill is expected in advance of the next meeting scheduled for March 8, 2021.

There was a discussion regarding how the proposed legislation would be paid for and whether the GHIP could absorb the costs considering the projected deficit. Sample forecasting is detailed in the long-term projections' presentation and discussion will be ongoing. Dir. Rentz will provide regular updates.

Disability Insurance Program
SBO has seen an increase in Level II & III Short Term Disability ("STD") appeals as well as increased complaints from employees and organizations regarding extended timeframes for pending and denied STD claims. SBO is reviewing internal policies and meeting regularly with agencies experiencing a high volume of claims. Short-term recommendations to improve administration and reduce the claim review and determination process will be presented to the Committee at an upcoming meeting.

SEBC Subcommittee Meetings
The Financial and Health Policy & Planning Subcommittees met in a combined meeting in January and February and have largely focused on 2021 OE planning, benefit modifications and updates in the financials/GHIP forecast, all of which will be included in today's discussion.

FINANCIALS

November 2020 Fund Equity Report – Mr. Giovannello, WTW

November was a high revenue month because of receiving an additional premium payment but will smooth in the coming months. Rebates were lower than expected at $10.2M for commercial and $7.7M for EGWP. The rebates are attributable to claims incurred in Q4 of FY20 at the onset of the pandemic and smoothing is expected next quarter. There was a $5.4M Coverage Gap discount payment. Other revenues of $416K included a missed performance guarantee payment from ESI. Claims were $5.9M above budget as care deferral began to re-emerge.

December 2020 Fund Equity Report – Mr. Giovannello, WTW

Claims were below budget by $2.7M and net income had a deficit of $10.1M bringing the YTD fund equity balance to $171.2M with a $2.8M variance to budget.

January 2021 Fund Equity Report – Mr. Giovannello, WTW

A year-end prescription true up reconciliation payment of $9.5M attributable to CY19, compared to last year's CY18 payment of $5.2M. The higher payment is because of increased pharmacy spend.

January claims generated a surplus of $1.5M with a YTD claims surplus of $4.4M with less than 1% variance to budget. The fund equity balance is $179.6M.

FY21 Q2 Financial Reporting – Mr. Giovannello, WTW

A review of the first 6 months of FY21 gross claims compared to FY20 reflects a 1.5% increase that aligns with the increase in membership. On a per-employee and per-member per-year basis medical claims reflect an increase of 0.4% and pharmacy reflects a decrease of 1% resulting from the timing of invoice payments; there were 12 ESI invoices in FY21 (commercial and EGWP) compared to 13 invoices in FY20 and if corrected for, pharmacy claims would reflect an increase of approximately 6%. It was noted that the first 6 months of FY20 did not reflect pandemic related claims.

When comparing FY21 actual to FY21 budget, medical claims are down 5%, but January claims were closer to budget; this is the result of the timing and the number of claims received.

Reductions were noted in the utilization and spend in preventive care, screenings, in-patient and emergency room admissions.

A reconciliation of operating expenses versus operating revenues between the WTW Financial Report and the Fund Equity Report noted that WTW reports what is expected to be earned in FY21 compared to the Fund report that reflects what was received in FY21.

GHIP Long Term Projection Recast & COVID-19 Cost Reporting and Utilization Analysis – Mr. Giovannello, WTW

Uncertainty around the pandemic continues. The impact will depend on many factors including but not limited to the level of care deferral that returns in FY21 and FY22, the potential care deferral that emerges in FY21, the cost of the vaccine, and the potential for new waves of infection.

Vaccine costs are currently covered by the Federal Government and the State is responsible for the administration costs. To date the cost to the State for administration is $50K. It is expected that the cost of the vaccine will eventually be shifted to the State.

Additional factors that will continue to be monitored include the shift to virtual care and the downstream impact from missed preventive screenings/immunizations, compounding mental health issues, and the unknown health needs of COVID-19 survivors. The $23.5M one-time COVID-19 reserve is included in projections.

Claims for FY20 Q4 came in $47.1M below budget, claims for FY21 Q1 came in $11.2M below budget and FY21 Q2 came in $8.3M above budget driven by the return of deferred care. February, March, and April claims are being tracked on a weekly basis to analyze trends and to support premium rate recommendations.

Sec. Magarik queried where the rebound claims were coming from. Mr. Giovannello responded that a more detailed utilization analysis by service by month is forthcoming but added that the return of care was across all categories.

It was noted that procedure codes and provider billing for the testing and treatment of COVID-19 are still evolving, and claims reported by the medical carriers may differ.

The YTD cost of COVID-19 testing (positive cases) and treatment claims for Highmark totals $10.7M for confirmed members and Aetna totals $2.7M. Highmark totals $9.6M in paid testing (negative cases) claims and Aetna totals $1.0M.

Aetna non-COVID-19 telemedicine claims continue to increase and total $57K with $4.0M in attributable claims. From January 1, 2020 Highmark had a total of $14.0M in claims attributable to telemedicine.

Mr. Taschner queried the delta between the unit cost for an in-person visit versus telemedicine. Mr. Giovannello responded that previously the telemedicine cost was fixed; however, telemedicine visits have shifted to being reimbursed the same amount as in-person visits. Additional analysis is forthcoming to determine if there has been an increase in total visit count.

Dir. Cade queried the cost disparity between Highmark and Aetna claims on a per-member basis. Mr. Giovannello responded that it cannot be confirmed that the provider and carrier claims are attributed to the same procedure codes and additional analysis is forthcoming. Dir. Cade noted the potential for federal reimbursement related to positive COVID-19 claims, and the importance of accuracy.

The CVS commercial contract savings has been incorporated into the long-term projections. The commercial contract will cover all 12 calendar months of FY22 and is projected to reduce allowable pharmacy claims by $7.6M and increase rebates by $14.3M. The EGWP contract will cover 6 calendar months of FY22 beginning January 1, 2022; the savings for remaining 6 months of FY22 is projected to reduce allowable pharmacy claims by $13.2M and increase rebates by $16.5M.

Mr. Taschner recalled that previously the Committee was presented with an estimated $200M savings over a three-year period and queried whether the estimates were too conservative. Mr. Giovannello responded that savings built into the RFP were on an allowed cost basis and the estimates presented include a cost share differential on the member side but added that the savings would continue to grow over years two and three.

Updated projections include spreading the return of deferred care into FY22, the increase in claims and premiums due to the growth in enrollment, and a cost of $160K for Aetna's essential health benefit changes related to accidental dental coverage.

Updated projections do not account for any future rate action or FY22 program or legislative changes including the proposed primary care reimbursement legislation estimated at an increase of $10.0M, copay changes for mental health parity analysis estimated at an increase of $370K, and a bariatric surgery carve-out to SurgeryPlus estimated at $355K -$1.4M in cost avoidance. A $46.5M projected surplus is projected through end of FY21 that includes a $9.5M CY19 EGWP true-up payment received January 2021 and a $23.5M COVID-19 reserve.

A rate increase in FY21 is not possible; however, without a premium increase or other savings initiatives, a deficit of $31.4M is projected through end of FY22. To smooth FY21 surplus over two years will require a 6.4% premium increase effective July 1, 2021, or a 7.8% increase without the COVID-19 reserve.

Targeting a $0 surplus by the end of FY22 without program changes or premium increases would require a 3.7% increase effective July 1, 2021; this recommendation would fall short of the recommendation to smooth surplus over two-years.

Dir. Cade queried the intended use of the COVID-19 reserve, noting that if it were added to the surplus it would be required to be smoothed over a two-year period. Mr. Giovannello responded that it was intended to be removed from the fund after the pandemic.

There was a discussion regarding the use of the COVID-19 reserve and how that correlates to any potential rate action. If the reserve is needed it would be reflected under operating expenses and would reduce the reserve by same amount, but if not needed then it would not be treated as a surplus and would be added back to the reserve fund.

The Committee would like to see an illustrative example that reflects projections that do not include the COVID-19 reserve.

The Committee discussed the impact of how smoothing the surplus over a two-year period would impact a rate increase for employees. Ms. Warnken suggested that the Financial Subcommittee review the current recommendation for smoothing the surplus as they consider the timing and level of a rate increase in FY22.

Emerging experience will continue to be tracked on a weekly basis to support a discussion around timing and level of potential rate action, including COVID-19 testing and treatment, care deferral by type of care, vaccine administration costs, emerging utilization and cost savings for GHIP initiatives.

2021 Open Enrollment & FY22 Planning – MS. JACYLN IGLESIAS

Open Enrollment ("OE") is scheduled for May 3 to 19, 2021 with virtual only events. SBO will not host health fairs but vendors have been asked to provide a short video of their programs and services and communications will include information on the CVS Caremark prescription benefits available to employees and non-Medicare retirees.

One OE course will be assigned to the HR/Benefit Representatives asking them to review their responsibilities prior to and during OE. One course will be assigned to employees to review the steps to take for OE and to review any changes that will occur for the plan year beginning July 1, 2021.

SBO will streamline communications and messaging. The Double State Share Form does not need to be completed until after OE but this year members have the option to complete it during OE.

The 2017 epilogue language allows the Committee to either roll over an existing election to the following plan year or implement an active enrollment that would require current and non-Medicare employees to participate in OE or be defaulted into a designated plan option. Historically, the Committee has opted to use strong messaging to encourage, but not require, participants to actively participate. Engagement in open enrollment has increased from 54.1% in 2017 to 83.4% in 2020 because of this strong messaging.

The Subcommittees did not recommend defaulting employees that do not actively participate in Open Enrollment. The Committee recognized the positive trend in employee engagement and agreed with the Subcommittees not to exercise the option to default employees into a plan.

The goal of the GHIP Strategic Framework is to, "strive for an incremental increase in unique users utilizing a specific point-of-enrollment or point-of-care engagement platform tool by 5% annually". The State provides employees with the myBenefitsMentor decision support tool by IBM Watson to help employees identify the lowest cost plan recommendation based on their historic medical costs including applicable dependents.

In 2018 the tool was used by 20% of active employees and non-Medicare pensioners during OE, 22% in 2019, and 27% during 2020; however, only 8.4% switched to the recommended plan, compared to 12.0% of those who did not use the tool but still selected the lowest cost plan that would have been recommended.

As a self-insured group health plan, the State is not required by the Affordable Care Act ("ACA") to offer Essential Health Benefits ("EHB"); however, to the extent that they do, they are prohibited from imposing any annual or lifetime dollar limits. Selecting a state benchmark is a legally authorized method for identifying EHB; the State selected South Carolina to assess alignment with the benchmark plan.

A recent review of GHIP provisions against selected EHB benchmark plans identified a need to add coverage for dental surgery due to accidents under the Aetna HMO and CDH Gold Plans (an increase of $155K annually). There is also a need to clarify language to plan documents regarding coverage for licensed care practitioners (e.g. nurse practitioners), for nutritional counseling for eating disorders, and for reconstructive surgery when performed to correct a functional defect that results from a birth defect.

The Mental Health Parity and Addiction Equity Act requires health plans providing mental health/substance use disorder benefits to provide those benefits in parity with medical/surgical benefits. A review is in process and may require a reduction in behavioral health copays for Aetna HMO plan members for an estimated cost increase of $370K.

The Committee voted to adopt SurgeryPlus as a third-party administrator of Centers of Excellence ("COE") in October 2018. A COE is defined as any medical facility or professional providing superior outcomes. In June 2019 the Committee voted to adopt an incentive strategy and program design to allow plan participants to have a choice of providers when accessing COEs for broader elective procedures. Members using a SurgeryPlus COE receive comprehensive benefits including additional financial incentive, concierge, care coordination, and travel benefits as needed.

SurgeryPlus savings results were reviewed for FY20. The budget included an estimated $500K in net savings. The actual realized savings for completed procedures was $370K; there are surgeries that were scheduled in FY20 that have not yet been completed. There was a greater variety and cost variation among the actual procedures over what was budgeted; there were more low-cost surgeries and fewer high-cost surgeries than budgeted.

Additionally, the cost of the incentive design was not factored into the original savings estimates as they were not finalized until after budget estimates.

There is an opportunity in FY22 to mandate bariatric surgery through SurgeryPlus. Currently GHIP members have the choice to use their medical plan or obtain bariatric surgery through the SurgeryPlus program. The medical carriers have had challenges with administering this benefit in the past, such as not applying the 25% coinsurance to members using non-COE facilities.

SurgeryPlus has no out-of-pocket cost sharing for members and can benefit members in terms of health outcomes, claim billing and adjudication, and concierge support to locate providers, schedule appointments, limit travel requirements, coordinate follow-up care, and more.

SurgeryPlus has participating providers in Delaware who will perform bariatric surgery on an inpatient or outpatient basis, and benefits are not an ACA EHB; therefore, the Committee has discretion in how to offer coverage for this benefit.

The net cost avoidance per procedure is estimated at $12K with a range of potential cost avoidance for FY22 estimated between $355K (at 1/4 of pre-COVID average) and $1.4M (at pre-COVID average) to be determined by the number of procedures. Additional considerations include the length of any grace period that may be offered for members who are scheduled to have bariatric surgery with a non-SurgeryPlus provider within a given period following the effective date of the carve out. Estimate also assumes that the financial incentive for using SurgeryPlus for this procedure is discontinued.

Mr. Taschner requested a summary of SurgeryPlus member satisfaction surveys specific to GHIP member utilization. Ms. Iglesias will prepare a follow up and include quality metrics as well.

Other considerations include communications and updates to plan documents and benefit summaries, including procedures for claim denials and appeals, as well as communicating the differences in clinical policy guidelines through Highmark, Aetna and SurgeryPlus.

Medical carrier considerations would include disabling coverage for specific procedure codes associated with bariatric surgery, scripting for carrier customer service and care management teams to ensure consistent messaging about this change, discussion of claims denials and appeal process, and updating online provider portals and member websites to reflect the carve-out arrangement.

Additionally, the clinical policy guidelines for SurgeryPlus bariatric surgery program are currently under review against medical carrier guidelines to determine any material differences in the member experience.

OTHER BUSINESS
No new business was presented.

PUBLIC COMMENT
Ms. Jacqueline Faulcon spoke on behalf of the Retirees, Educators, Administrators of Delaware Area Association. Her members attempted to get vaccinated for COVID-19, however; members found the information was hard to locate and unclear. Dir. Rentz responded that she will follow up with information on upcoming vaccination events.

EXECUTIVE SESSION
A MOTION was made by Treasurer Davis and seconded by CG Jones to move into Executive Session at 3:48 p.m. to discuss the Express Scripts bid protest and a confidential Level III Disability Appeal.
MOTION ADOPTED UNANIMOUSLY

ADJOURNMENT
A MOTION was made by Sec. Magarik and seconded by Treasurer Davis to adjourn the meeting at 04:46 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