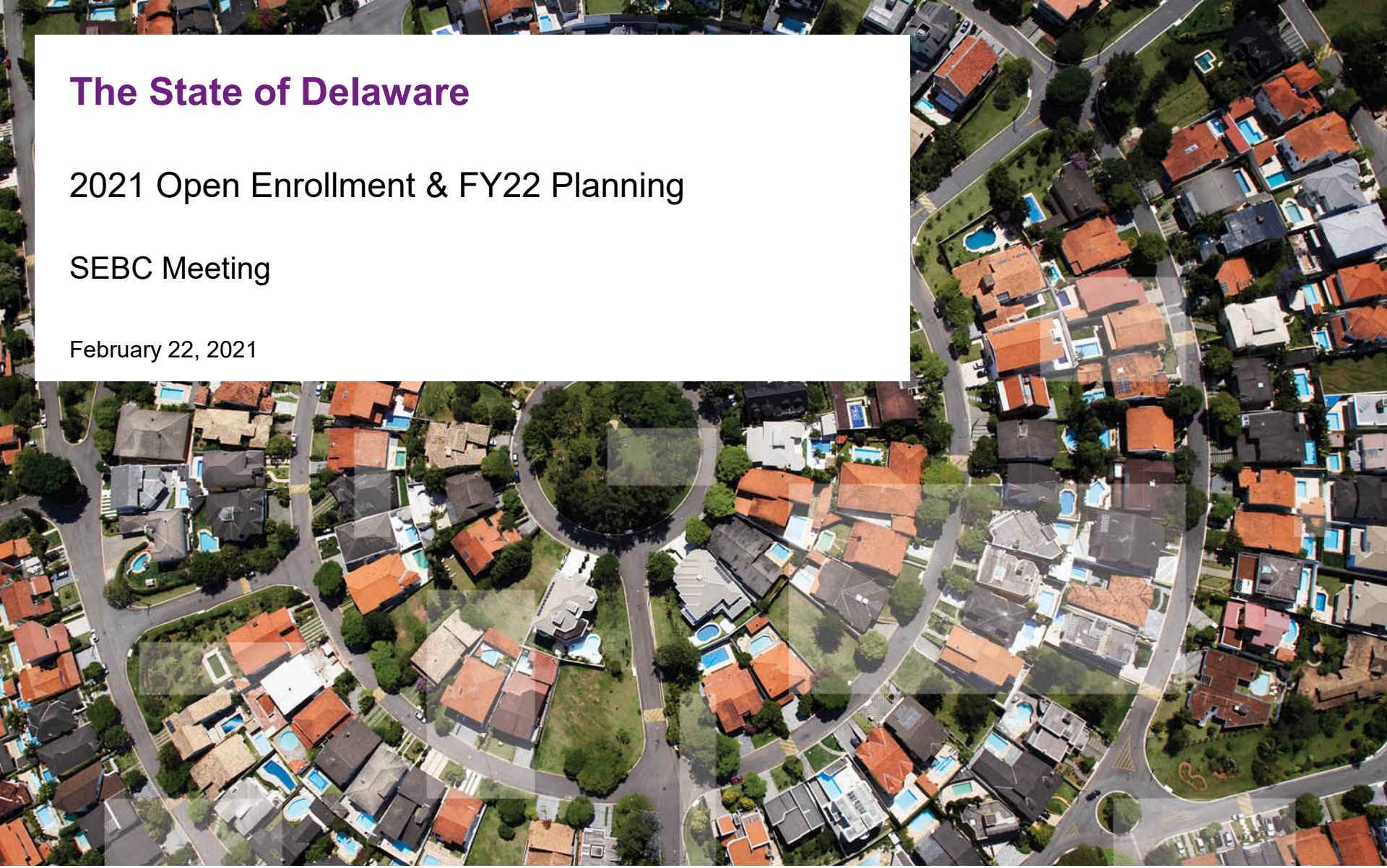
The State of Delaware

2021 Open Enrollment & FY22 Planning

SEBC Meeting

February 22, 2021



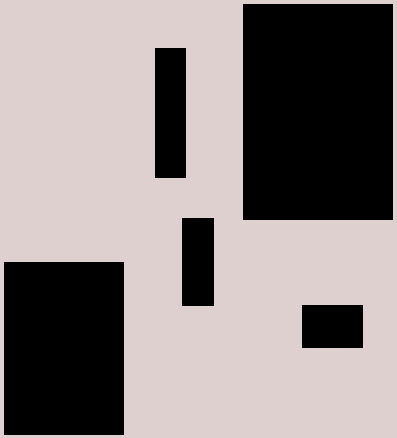
Willis Towers Watson

Today's discussion

- 2021 Open Enrollment
- Compliance updates
- SurgeryPlus program – FY20 outcomes and FY22 planning considerations

- Appendix
  - SBO Open Enrollment overview
  - Section 23 FY18 budget epilogue – open enrollment

2021 Open Enrollment



2021 Open Enrollment

- Open Enrollment for State employees, employees of participating groups, and non-Medicare pensioners will start Monday, May 3, 2021 and run through Wednesday, May 19, 2021
- Given the current COVID-19 pandemic, SBO will not hold health fairs
  - Instead, short informational videos co-created with GHIP benefits vendors will be posted for employees on the Open Enrollment page of the SBO website
- Training for HR/Benefit Reps:
  - One (1) online course[1] providing overview of responsibilities before, during and after Open Enrollment
  - Encourage outreach to SBO Customer Service with questions prior to start of and during Open Enrollment
- Communications to employees:
  - Will have streamlined content and messaging
  - One (1) online course[1] providing overview of Open Enrollment process and overview of any changes
- Double State Share (DSS) Form for eligible employees does not have to be completed until after Open Enrollment ends; however, employees can complete the DSS Form during Open Enrollment if they wish

1 Further details on these courses provided in Appendix.

Open Enrollment engagement

- Active enrollment encourages more employees to review the options available and make an optimal plan choice for their situation which can drive savings for the State and employees
- In 2017, budget epilogue language was updated to allow the SEBC to default employees into a health plan as a consequence of not actively engaging in Open Enrollment (see appendix)
- Since that time, the SEBC has opted to strongly encourage employees and non-Medicare pensioners to actively engage in Open Enrollment, but has opted against defaulting employees who do not participate in the enrollment process
- The approach taken by the SEBC has been effective in increasing State employee engagement in recent years

OE Period	State Agency Average	State Average
2020 OE (for FY21)	85.8%	83.4%
2019 OE (for FY20)	85.8%	84.7%
2018 OE (for FY19)	84.9%	81.8%
2017 OE (for FY18)	60.1%	54.1%

Open Enrollment engagement (continued)

- The option to default employees into a health plan as a consequence of not actively participating in the enrollment process was discussed at the February 18, 2021 Combined Subcommittee meeting
  - Would only apply to current employees, not non-Medicare pensioners
- Subcommittee members recommended that the SEBC does not exercise the option to default employees who do not participate in the enrollment process, consistent with the approach taken by the SEBC in recent years

For discussion today and at the March 8, 2021 SEBC meeting:

- What are SEBC members' perspectives on defaulting employees who do not actively participate the 2021 Open Enrollment process?

Enrollment decision support tool

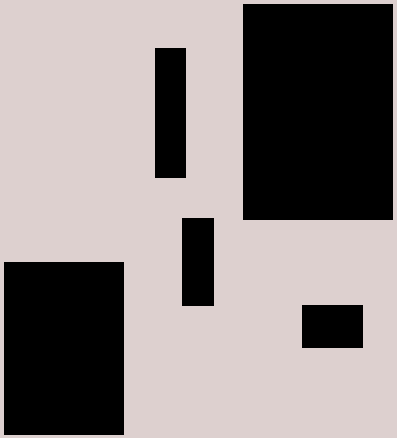
- The State provides employees with an enrollment decision support tool to aid in medical plan selection each year: IBM Watson's myBenefitsMentor tool
  - myBenefitsMentor tool provides employees and non-Medicare pensioners with recommendations for the lowest cost medical plan option based on the employee's or pensioner's historical medical costs (including their covered dependent costs, if applicable)
  - Utilization rate among employees and non-Medicare pensioners continues to increase each year
    - 2020 OE (for FY21): 27%
    - 2019 OE (for FY20): 22%
    - 2018 OE (for FY19): 20%
  - While the myBenefitsMentor tool was used by nearly 27% of employees and non-Medicare pensioners during FY21 Open Enrollment, a relatively small percentage selected the recommended plan
    - Only 8.4% of users selected 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 for them

Enrollment decision support tool (continued)

- Regardless of whether the SEBC exercises the option to default employees who do not participate in the enrollment process, employees and non-Medicare pensioners would benefit from continued use of the myBenefitsMentor tool, which supports a goal within the GHIP Strategic Framework:
  - *In light of the GHIP's changing demographic profile, strive for an incremental increase in unique users utilizing a specific point-of-enrollment and/or point-of-care engagement platform/consumerism tool[1] by at least 5% annually*

1 Through FY2021, this tool will continue to be administered under the purview of the SBO. Post-FY2021, selection of a specific engagement platform / consumerism tool will be at the discretion of the SEBC.

Compliance updates



Essential Health Benefits (EHBs)

Overview	▪ ACA[1] introduced the concept of EHBs ▪ Defined by the Department of Health and Human Services (HHS); includes items and services in ten general categories of health benefits ▪ Self-insured group health plans are not required to offer EHBs. However, to the extent they do cover an EHB, the ACA prohibits the imposition of any annual and lifetime dollar limits. Additionally, many self-insured plans do provide coverage for a broad range of services, many of which fall under one or more of the 10 EHB categories. ▪ Selecting a state benchmark is a legally authorized method for identifying EHBs; HHS has approved and authorized benchmark plans in all 50 states
Compliance obligations of the GHIP	▪ Review GHIP provisions against selected EHB benchmark plan (South Carolina) to assess alignment with the benchmark plan
Outcome for FY22 medical plan	▪ Addition of coverage for dental surgery due to accidents under the HMO and CDH Gold plans (total cost increase: $155,000 annually) ▪ Adding language to plan documents to clarify the GHIP's current coverage for visits with other licensed health care practitioners (such as 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

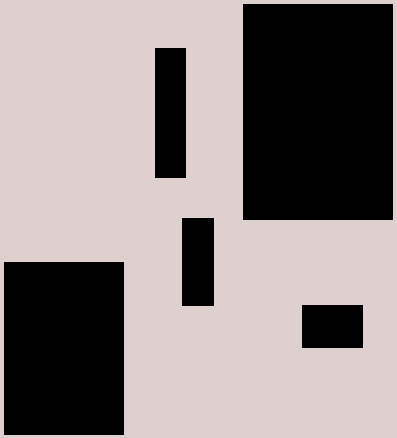
1 Patient Protection and Affordable Care Act

Mental Health Parity & Addition Equity Act (MHPAEA)

Overview	▪ Requires health plans providing mental health/substance use disorder (MH/SUD) benefits to provide those benefits in parity with medical/surgical (M/S) benefits ▪ Health plans that impose financial requirements (e.g., deductibles, copayments) or quantitative treatment limitations (e.g., # visits, days of coverage) may not be applied more stringently to MH/SUD benefits than M/S benefits ▪ Non-quantitative treatment limitations (e.g., prior authorization, utilization review) may not be applied more stringently to MH/SUD benefits than M/S benefits ▪ Increased focus on financial requirements/quantitative treatment limits, and public inquiries related to MHPAEA are on the rise
Compliance obligations of the GHIP	▪ SPDs/plan document review of treatment limitation language ▪ Claims/audit review ▪ Review to ensure program structure does not violate quantitative/non-quantitative treatment limitation rules ▪ Appropriate disclosures to participants (medical necessity; benefit denials)
Outcome for FY22 medical plan	▪ MHPAEA review in progress; may require reduction in behavioral health copays for Aetna HMO plan (total cost increase: $370,000 annually)

SurgeryPlus program

FY20 outcomes and FY22 planning considerations



SurgeryPlus

Overview

- SEBC voted to adopt SurgeryPlus as a third-party administrator of Centers of Excellence (COEs) in October 2018
  - A COE is a medical facility and/or professional that has been identified as delivering high quality services and superior outcomes for specific procedures or conditions
  - Prior to then, access to COEs was available to GHIP participants through Highmark and Aetna, although there are differences between their COE offerings in terms of the scope of COE-eligible procedures and specific COE providers
- In June 2019, the SEBC voted to adopt a “carve-out” COE program design, communication and engagement strategy, incentive plan, and scope of covered services proposed by SurgeryPlus and developed with input from the Health Policy & Planning Subcommittee
  - Program design provided GHIP participants with the following choice of COE providers for a broad set of elective (non-emergency) procedures: plan participants could access a COE provider designated by their medical plan or they could access a SurgeryPlus COE provider
  - Use of SurgeryPlus COEs included additional incentives for the plan participant, including concierge member services to coordinate care on the plan participant’s behalf, travel benefits (hotel accommodation, mileage reimbursement, etc.) and a financial incentive (e.g., $2,000 for bariatric surgery)

FY20 program outcomes

Savings – actual vs. estimated

- FY20 budget included an estimated $500,000 in net savings associated with implementing the carve-out program design and incentive plan proposed by SurgeryPlus
- Actual FY20 experience reflects a net savings of approximately $370,000
  - Data below reflects completed procedures only; does not reflect procedures that were scheduled but not yet completed prior to the end of FY20
- Key drivers of differences between estimated and actual savings from FY20:
  - Actual number of lower cost procedures were completed in FY20 than estimated (examples: colonoscopies, endoscopies)
  - Greater variety and cost variation among the scope of procedures actually offered vs. estimated
    - Estimated scope only included a subset of the COE-eligible procedures offered to the GHIP today (i.e., knee/hip replacements and spine surgery)
  - Incentive design was developed after the FY20 budget was finalized and was not factored into the estimated savings

SurgeryPlus FY20 experience	Estimated	Actual
Total number of procedures by participating providers	53	81
Gross Savings		
Estimated medical carrier claims cost	$1,881,000	$1,182,000
SurgeryPlus claim cost	$1,027,000	$509,000
Gross savings from SurgeryPlus	**$854,000**	**$673,000**
Admin Fees and Other Expenses		
SurgeryPlus administrative fees	$334,000	$196,000
Financial incentives	$0	$95,000
Travel benefits	$0	$13,000
Net savings to the State	**$520,000**	**$369,000**
FY20 budgeted savings[1]	**$500,000**	
Difference with FY20 budget		($131,000)

1. $500,000 savings also is net of estimated member cost share (approx. $20,000), which assumed members would pay the same out-of-pocket cost for using SurgeryPlus providers as they would to use the COEs available through the medical carriers.

FY22 planning – bariatric surgery

Overview of provider options

- One opportunity for consideration is mandating the use of the SurgeryPlus network for bariatric surgeries
- Currently, GHIP members who want to obtain these procedures have the choice to use their medical plan's provider network (i.e., through Highmark or Aetna) or obtain the surgery through the SurgeryPlus program
- There is potential for significantly different member experiences when seeking this surgery through the medical plan vs. the SurgeryPlus program in terms of:
  - Concierge support for locating a provider, scheduling an appointment, coordination of follow-up care with the member's PCP, etc.
  - Availability of participating providers
  - Health outcomes associated with the selected surgical provider
  - Claim billing and adjudication process
  - Travel benefits associated with using a provider of excellence
- The medical carriers have had challenges with administering this benefit for the State in the past, such as not applying the 25% coinsurance to members using non-COE facilities

Bariatric surgery

Carve-out opportunity for FY22

- SurgeryPlus has indicated that some plan sponsors within its book of business are starting to mandate use of the SurgeryPlus program for a limited set of procedures
  - Bariatric surgery is the most popular procedure to “carve-out” entirely to SurgeryPlus
- There are several potential benefits to GHIP participants and the plan if the State were to do this:
  - Travel requirements for plan participants would be limited
    - SurgeryPlus now has participating providers in Delaware who will perform bariatric surgery on an inpatient or outpatient basis
  - This procedure requires a lengthy coordination process with patients prior to surgery, and the SurgeryPlus program could support patients through this process via the concierge services offered through the program
  - Potential for members to share in the potential savings realized through steering members to SurgeryPlus providers
- The SEBC has discretion in how to offer coverage for this benefit -- bariatric benefits are not an ACA Essential Health Benefit; therefore, not required to be covered at all

Bariatric surgery

Potential cost avoidance for FY22

- Potential cost avoidance associated with carving out bariatric surgery is highly dependent upon the number of procedures that will be conducted during FY22
- Several factors can impact number of procedures, including:
  - Continued impact of COVID-19 on deferral of elective procedures, and
  - Length of any grace period offered for members who are scheduled to have bariatric surgery with a non-SurgeryPlus provider within a given period of time following the effective date of the carve-out
- Number of procedures noted below are based on a range leading up to the average annual bariatric surgery procedures in the two years prior to the COVID-19 pandemic (Calendar Years 2018-2019)
- Estimate below also assumes financial incentive for using SurgeryPlus program is discontinued, given that GHIP coverage of bariatric procedures would only be available through the SurgeryPlus program in this scenario

Estimated FY22 cost avoidance	per procedure
Gross Cost Avoidance	
Estimated medical carrier claims cost	$37,000
SurgeryPlus claims cost	$18,000
Gross Cost Avoidance from SurgeryPlus	**$19,000**
Administrative Fee and Other Expenses	
SurgeryPlus administrative fee	$7,000
Financial incentive	$0
Travel benefits	$175
Net Cost Avoidance to the State	**$11,825**

	1/4 pre-COVID average	1/2 pre-COVID average	Pre-COVID average
Total number of procedures	30	60	120
Total Estimated FY22 Cost Avoidance to the State	**$355,000**	**$710,000**	**$1,419,000**

Bariatric surgery

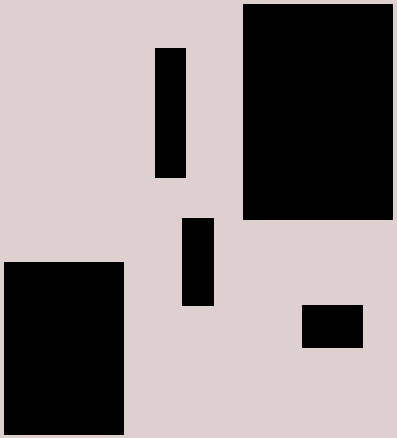
Other considerations with carve-out opportunity

- Member-facing considerations:
  - Carve-out would require member communications and updates to plan documents and benefits summaries describing this change, along with procedures for claim denials and appeals
    - Opportunity to leverage communications for the upcoming OE period to communicate this change; would require SEBC approval by March 2021 to meet printer deadlines for FY22 OE
    - Members would need to understand any differences between current bariatric surgery clinical policy guidelines through Highmark and Aetna and SurgeryPlus
  - Description of benefits and restrictions would need to be added to plan summaries
  - Grace period may be necessary for members who are scheduled to have bariatric surgery with a non-SurgeryPlus provider within a given period of time following the effective date of the carve-out
- Medical carrier considerations
  - Coverage for specific procedure codes associated with bariatric surgery would need to be “turned off”
  - Scripting required for carrier customer service and care management teams to ensure consistent messaging about this change; also, referral protocols should be established and tracked
  - Discussion of claim denials and appeals process would be necessary
  - Online provider portals and member websites would need to be updated to reflect carve-out arrangement (i.e., non-coverage of bariatric surgery through Highmark and Aetna plans and coverage only through SurgeryPlus)
  - 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

Next steps

- Subcommittee members have been asked to provide feedback on the potential opportunity to carve out bariatric procedures to the SurgeryPlus program
- Additional discussion related to this topic is planned for the March 4, 2021 Subcommittee meeting
  - Recommendations from Subcommittee members will be presented to the SEBC
- The SEBC will be asked to determine whether coverage of bariatric surgery will be carved out to the SurgeryPlus program effective 7/1/21, or if plan participants will continue to have a choice of surgery providers
  - Item will be presented for a vote at the March 8, 2021 SEBC meeting

Appendix



2021 Open Enrollment

- Open Enrollment for all groups will start **Monday, May 3, 2021 and run through Wednesday, May 19, 2021.**

- Given the current COVID-19 pandemic, SBO will not hold health fairs. Instead, we are working with our benefit vendors to create short informational videos that will be posted on the Open Enrollment page of the SBO website for employees to access while preparing for Open Enrollment.

- Assignment of online courses:
  - SBO will assign one online course to HR/Benefit Representatives on April 6, 2021 titled ***"HR/Benefit Rep Responsibilities For Open Enrollment"*** that reviews their responsibilities prior to, during and after Open Enrollment to best support their employees.
  - SBO will assign one online course to benefit-eligible employees on April 7, 2021 titled ***"Navigating Open Enrollment"*** that reviews the steps they need to take prior to, during and after Open Enrollment, as well as any changes that will occur for the plan year beginning July 1, 2021.
  - Activities and questions within the online courses will be streamlined this year.
  - Online courses will be available and tracked in the Delaware Learning Center (DLC) and via a separate website link (for those who do not have access to the DLC).
  - Completion due date for the online courses is April 30, 2021.

2021 Open Enrollment

- SBO encourages outreach to SBO Customer Service with questions prior to start of and during Open Enrollment.
- SBO will streamline Open Enrollment communications, including content and messaging.
- The Double State Share (DSS) Form for eligible employees does not have to be completed until after Open Enrollment ends; however, employees can complete the DSS Form during Open Enrollment if they wish.

2021 Open Enrollment

- All benefit-eligible employees are **required to actively participate** in the Open Enrollment process each year.

Actively participate between **May 3 - 19, 2021**
by completing these three simple steps:

- ***STEP ONE:*** Log in to State of Delaware Employee Self-Service (employeeselfservice.omb.delaware.gov) to enroll, confirm or waive your health, dental and/or vision coverage.

- ***STEP TWO:*** Complete the online Spousal Coordination of Benefits Form only if you will be covering your spouse under a Highmark Delaware or Aetna Health Plan as of July 1, 2021.

- ***STEP THREE:*** Check out the additional benefits available, including the Flexible Spending Account (FSA) Plan, Accident & Critical Illness Insurance and Group Universal Life (GUL) Insurance.

Section 23 FY18 budget epilogue – open enrollment

Employees of the State of Delaware who are enrolled in a health insurance benefit plan must actively participate in the open enrollment process each year by selecting a health plan or waiving coverage. Should such employee(s) neglect to enroll in a plan of their choice during the open enrollment period or waive coverage, said employee(s) and any spouse or dependents enrolled at the time will be enrolled into the default health plan(s) as determined by the State Employee Benefits Committee.