**MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE**
**May 10, 2021**

The State Employee Benefits Committee (the "Committee") met at 2:00 p.m. on May 10, 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 Colleen Davis, State Treasurer, Office of the State Treasurer
Controller General Ruth Ann Jones, Office of the Controller General ("OCG")
Secretary Molly Magarik, Department of Health & Social Services ("DHSS")
The Honorable Trinidad Navarro, Insurance Commissioner, Insurance Coverage Office
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)

*Committee Members Not Represented or in Attendance:*
The Honorable Bethany Hall-Long, Lieutenant Governor, Office of the Lieutenant Governor

*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. Wendy Beck, Highmark Delaware
Ms. Rebecca Byrd, ByrdGomes Group
Ms. Michelle Carpenter, PHRST
Ms. Julie Caynor, Aetna
Ms. Alyssa Chandler, Administrative Specialist, SBO, DHR
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. Sandy Hart, IBM Watson Health
Ms. Katherine Impellizzeri, Aetna
Ms. Heather Johnson, Controller, DHR
Ms. Lizzie Lewis, Hamilton Goodman Partners
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walt Mateja, IBM Watson Health
Ms. Emily Molinaro, Fiscal and Policy Analyst, OMB
Ms. Katherine Nedelka, HRIS Specialist, PHRST
Mr. Michael North, Aetna
Ms. Paula Roy, Roy & Associates
Ms. Carrie Schiavo, Delta Dental
Ms. Judi Schock, Deputy Principal Asst., OMB
Mr. Robert Scoglietti, Deputy Controller General, OMB
Ms. Martha Sturtevant, Exec. Sec., SBO, DHR – Recorder
Ms. Joanne White, Member of the Public

**CALLED TO ORDER**
Director 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 Secretary Magarik and seconded by Mr. Taschner to approve the minutes from the April 19, 2021 meeting of the State Employee Benefits Committee.
MOTION ADOPTED UNANIMOUSLY

**DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ**

*Subcommittees Updates*

The Subcommittees met in a combined session on May 6, 2021. Member feedback will be incorporated into the discussion and presentation before the Committee today.

*Legislative Updates*

The Primary Care Reform Collaborative bill to increase reimbursements to primary care has been introduced as SB 120. The bill does not apply to the GHIP; therefore, there will not be a fiscal note from DHR. In addition to the increases in PC reimbursements, the bill would set caps on total aggregate spend in areas outside of primary care to balance increases by limiting additional growth in healthcare spend and establish through regulation, mandatory minimums for payment innovations, including alternative payment models and provider price increases. The bill was released by the Senate Executive Committee and has been assigned to Senate Finance. Public comment at the hearing was significant in both support and opposition of the bill.

Secretary Magarik stated that amendments to the legislation are anticipated as discussions continue between bill sponsors and stakeholders. Commissioner Navarro added that he had concerns that the legislation will sunset which does not address the concerns long-term.

Mr. Taschner queried whether any amendments would apply to the GHIP. Director Rentz responded that amendments were not expected to impact the GHIP directly.

*2021 Open Enrollment*

Open Enrollment ("OE") is open from May 3 to May 19, 2021. Changes approved by the Committee to increase the Dependent Care FSA Maximum election to $8,000 for the period of July 1 to December 31, 2021, for employees who choose to enroll for the FY22 plan year were incorporated.

*Request for Proposal Updates:*

The Third Party Administrator Request For Proposal ("RFP") for Health Plan Administration was advertised on April 26, 2021. An overview of the scope and goals will be reviewed later in the agenda.

**FY21 Q3 FINANCIAL REPORTING – MR. CHRIS GIOVANNELLO**

There was a review of the FY21 Q3 on an incurred basis compared to the prior year and relative to budget.

Gross claims for Q3 are up 4.1% over FY20. Pharmacy claims are understated as there is one less invoice compared to FY20. Without adjusting for the missed pharmacy invoice, the overall total cost per employee per year is up 2.2%, and up 2.6% per member per year.

Relative to budget, the total program costs are down 0.8% due to the timing of medical vendor claims; there is one less medical invoice.

Director Cade queried whether the increases had been accounted for in long-term budget projections. Mr. Giovannello noted that the Q3 comparison appears more favorable than the long-term projections because Q3 did not include the impact of COVID-19. A further review will be provided later in the agenda.

**GHIP LONG-TERM PROJECTION RECAST – MR. CHRIS GIOVANNELLO**

There were significant reductions in GHIP health care costs during CY20 due to the impact of deferred care that exceeded the costs related to the testing and treatment of COVID-19. The impact of the pandemic on the GHIP remains largely unknown and depends on many factors, including the level of care deferral that returns, the shift of vaccination costs to the state, service utilization (e.g., virtual care), the impact of missed preventive screenings, compounding mental health issues, and additional unknown health needs of COVID-19 survivors.

On July 27th, 2020, the SEBC approved a one-time COVID-19 reserve of $23.5M in FY21.

Through March, FY21 claims ran $6.7M above budget, and April medical claims exceeded budget by an additional $2.6M. May and June's claims are projected to trend above budget.

Mr. Taschner queried over what period the GHIP expects to absorb pent-up demand before returning to normal. Secretary Magarik asked to clarify whether the return of deferred care is defined as missed care that has returned or if it includes claims resulting from a lack of care continuity. Mr. Giovannello responded that the return of deferred care is calculated by claim levels above budget and added that approximately half of FY20 Q4 and FY21 Q1 claims are estimated to return with claims normalizing by the end of FY22 but added that long-term trends resulting from missed care will continue to be monitored.

GHIP claims paid for COVID-19 testing and treatment totaled $23.0M through March 2021 including $18.7M in treatment claims for a total of 5,811 patients ($17.1M in claims for 786 admits), and $4.3 in testing claims (DNA RNA and antibody tests).

The projected FY21 budget of $899.2M has been revised up $9.8M from FY21 Q2 and reflects actual operating expenses through March 2021, April 2021 claims, and estimated claim levels for May and June.

The FY21 and FY22 budgets reflect Other Revenues based on when revenues will be earned (received by the GHIP Fund) rather than when revenues will be incurred by the plan. FY21 Other Revenues reflect actual payment projections through Q4 and no longer captures anticipated true-up amounts to be earned in CY21 and CY22.

Budget projections have been revised. There is a projected $25.9M surplus projected for FY21 and does reflect the $23.5M COVID-19 reserve. A deficit of $47.0M is projected for FY22.

The FY22 projected shortfall is $72.9M; this is projected by subtracting operating expenses from operating revenues and less any change in reserve (i.e., $991.6M - $1,083.6M – ($19.1M) = $72.9M) and is the amount needed to fund FY22 so that there is no change in surplus relative to FY21 (FY21 surplus of $25.9M + $47.0M deficit = $72.9M).

On January 14th, 2019, the Financial Subcommittee recommended to the Committee to smooth available surplus over two years. This recommendation was intended to minimize the need for significant rate increases in years with poor claims experience and minimizes the volatility on year-over-year increases in member contributions. The Financial Subcommittee included a recommendation to revisit surplus smoothing methodology annually.

If no other program changes, target smoothing FY21 surplus ($25.9M) over 2 years requires a 14.2% rate increase effective January 1, 2022. If no other program changes, to target a $0.0 surplus by end of FY22 requires an 11.0% rate increase effective January 1, 2022.

Absent program changes or premium rate increases, the GHIP will deplete the health fund surplus during FY22, even with the release of COVID-19 reserve.

Mr. Taschner requested estimates for rate increases that would be effective October 1, 2021. Mr. Giovannello will follow up.

The one-time COVID-19 reserve of $23.5M was intended to maintain the solvency of the Fund under adverse scenarios directly or indirectly related to COVID-19. It was recommended to review reserve levels more frequently (e.g., quarterly) until the pandemic has subsided and claim levels are stabilized.

Director Cade queried whether the long-term projections and rate increase estimates included surplus smoothing and releasing the COVID-19 reserve. Mr. Giovannello confirmed adding that the COVID-19 reserve has no impact on necessary rate action if the full surplus is used.

Secretary Magarik queried how any federal reimbursements that might be received would be factored into the projections. Director Cade responded that approximately $16.0M in COVID-19 related claims had been identified for reimbursement but he did not think it would meaningfully impact the GHIP as it pertains to the deficit.

Mr. Taschner stated that in addition to increased premium rates, the upcoming Third Party Administrator contract may be able to help address the shortage through increased competition and reduced operating expenses.

Claims will be frequently monitored for emerging experience in addition to monitoring the emerging utilization and cost savings for GHIP initiatives adopted to date. The Financial Subcommittee will be tasked with recommending the timing and level of rate increase for FY22.

**MEDICAL THIRD PARTY ADMINISTRATION ("TPA") - MS. JACYLN IGLESIAS, WTW**

There was a review of market dynamics affecting the GHIP going into the FY16 Medical Third-Party Administration ("TPA") Request for Proposal ("RFP") including the passage of the Affordable Care Act ("ACA") in 2010 that began to shift accountability to the health care delivery system to better manage outcomes and lead to a focus on value-based contracting with medical providers, the passage of House Bill 81 in 2011 specified the types of GHIP state-level medical plan options and established participant cost-sharing parameters, the Delaware Health Care Commission developed the Delaware Health Innovation Plan in 2013, which led to the establishment of the Delaware Center for Health Innovation in 2014 to focus on health care payment reform, and the State Employees Health Plan Task Force established in response to the FY16 Health Fund deficit.

The outcomes of the 2016 Medical TPA RFP were reviewed. The GHIP remained with Highmark Delaware and Aetna (a requirement for a single administrator for each type of plan resulted in the elimination of Highmark HMO and Highmark CDH Gold plans), adoption of value-based agreement with Aetna and Christiana Care for the HMO plan, and the adoption of enhanced care management for Aetna HMO ("CareVio") and Highmark PPO and First State Basic plans ("CCMU"). There were no changes to the Highmark Special Medicfill Medicare supplement plan.

Nationally there has been a shift toward consolidating TPAs and Pharmacy Benefit Managers ("PBM") and continued emphasis on payment for value when contracting with medical contractors. Additionally, the COVID-19 pandemic transformed the evolution of health care delivery.

At a state-level, independent practices continue to consolidate with larger health care systems, Delaware established the Health Care Spending Benchmark, and several working groups have focused on broader state healthcare considerations including primary care, delivery system transformation, prescription drug purchasing, and the state's liability for retiree medical expenses.

The GHIP has seen a favorable trend over the last five years attributable to key changes in the GHIP design and offerings that resulted from the adoption of a Strategic Framework as well as the COVID-19 experience creating additional favorability in the later part of CY20.

Mr. Taschner stated that HB 81 was not a healthcare bill and was also about pensions. He added that it was misleading to say that the bill limits the Committee's ability to increase revenue, but rather the bill limits how the cost is shifted to plan participants. Secretary Bonner responded that a review of HB 81 is not intended to negate the efforts of HB 81.

There was a review of the goals outlined in the 2021 Medical TPA RFP.

Bidders will be asked to support the goals of the Strategic Framework by increasing the proportion of spend through advanced alternative payment models, reducing per-member cost for diabetic members, limiting total cost of care inflation, and offering various decision support tools to increase employee engagement.

Bidders should provide competitive financial terms including provider reimbursement rates, administrative fees, and performance guarantees as well as offer solutions that invest in primary care and support the affordability targets as defined by the Delaware Department of Insurance's Office of Value-Based Health Care Delivery.

Bidders should support the GHIP's programs and plan offerings by administering current plans, support plan provisions that optimize the effectiveness of GHIP benefit offerings, integrate with other programs and vendors supporting the GHIP, maintain a provider network that meets current and future state goals of the GHIP, provide supplemental coverage to Medicare-eligible retirees and their Medicare-eligible dependents, and support other state-level health care initiatives.

Bidders should be able to deliver on core functions of a medical TPA including claims administration, provider network, care management, member services, care navigation support, online tools and resources, communications support, account management, reporting, participation in the DHIN, and the ability to coordinate with Delaware community health resources.

Bidders will be expected to articulate how they can meet the goals of the GHIP Strategic Framework under the requirements of the Delaware Code as well under an alternative future state.

The Medical TPA RFP was posted to Delaware's Bid Solicitation Directory on April 26, 2021, with the Intent to Bid deadline on April 30, 2021.

Several organizations have indicated an interest in submitting proposals, including Highmark and Aetna. There was a mandatory conference call with bidders on May 5, 2021. Questions from bidders are due May 14, 2021, and responses to bidder questions are targeted for release on May 28, 2021. The bid deadline for RFP participants is June 18, 2021.

The analysis of proposals will be conducted between June and August 2021 and will include an evaluation of how bidders will support the GHIP as designed today, how they could achieve the goals of the Strategic Framework without the current limitations in place as well as an analysis of Medicare options to determine any financial benefits to the GHIP including member communications if a decision were made to move away from the current Medicare supplement offering.

Finalist interviews are scheduled for August 23 and 24, 2021. The Proposal Review Committee recommendation to the SEBC will be presented in late 2021.

Effective dates for contract awards through this RFP process are July 1, 2022, for active employees and non-Medicare pensioner plan options, and January 1, 2023, for the Medicare retiree plan option.

Mr. Taschner queried whether the Medicare options requested from bidders were an extension of the work began by the Executive Order 34 Committee. Director Rentz responded that the analysis will evaluate the Medicare supplement options but that it could be integrated into the scope of EO 34.

Director Rentz encouraged the Committee to fully participate in the RFP process.

**OTHER BUSINESS**
No new business was presented.

**PUBLIC COMMENT**
No public comment.

**ADJOURNMENT**
A MOTION was made by Secretary Bonner and seconded by Ms. Tucker to adjourn the meeting at 3:25 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